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: 14-1329	PERIOD FROM 7/ 1/2007 TO 6/30/2008	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 12/ 1/2008 TIME 17:20

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:
MORRISON COMMUNITY HOSPITAL 14-1329
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

_____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX
			A	B	
		1	2	3	4
1	HOSPITAL	0	-2,561	-7,126	0
3	SWING BED - SNF	0	114,669	0	0
5	HOSPITAL-BASED SNF	0	0	0	0
9	RHC	0	0	-5,582	0
9 .01	RHC II	0	0	9,956	0
100	TOTAL	0	112,108	-2,752	0

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 303 JACKSON P.O. BOX:
1.01 CITY: MORRISON STATE: IL ZIP CODE: 61270- COUNTY: WHITESIDE

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	MORRISON COMMUNITY HOSPITAL	14-1329		8/ 1/2003	N	O	O
04.00 SWING BED - SNF	MORRISON SWING BED	14-Z329		8/ 1/2003	N	O	N
06.00 HOSPITAL-BASED SNF	MORRISON SNF	14-5274		8/13/1974	N	P	O
14.00 HOSPITAL-BASED RHC	MORRISON COMMUNITY HOSPITAL CLINIC	14-3981		7/ 1/1996	N	O	O
14.01 HOSPITAL-BASED RHC 2	MERCY CLINIC OF SAVANNA	14-3481		7/25/2006	N	O	O

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

		1	2
18	TYPE OF CONTROL	10	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1
20	SUBPROVIDER	

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.		
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106?	N	
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC 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		
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		
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO.	N	
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	N	
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.	N	
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		/ / / /
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		/ / / /
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		/ / / /
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		/ / / /
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.		/ / / /
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		/ / / /
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		/ / / /
24	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION IN COL. 3.		/ /
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COLUMN 3.		/ /
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N	
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	N	
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.		
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	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 12/31/2003
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	Y

		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)

		%	Y/N
28.03	STAFFING	45.12%	Y
28.04	RECRUITMENT	0.00%	
28.05	RETENTION	0.00%	
28.06	TRAINING	0.11%	Y
28.07		0.00%	
28.08		0.00%	
28.09		0.00%	
28.10		0.00%	
28.11		0.00%	
28.12		0.00%	
28.13		0.00%	
28.14		0.00%	
28.15		0.00%	
28.16		0.00%	
28.17		0.00%	
28.18		0.00%	
28.19		0.00%	
28.20		0.00%	

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

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

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

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

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

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:	60,872	
	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 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 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

MULTICAMPUS

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

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL1. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

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

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	I/P DAYS / O/P VISITS / TRIPS TITLE V	TITLE XVIII	NOT LTCH N/A	TOTAL TITLE XIX
		1	2	2.01	3	4	4.01	5
1	ADULTS & PEDIATRICS	25	9,150	6,432.00		158		3
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					1,793		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	25	9,150	6,432.00		1,951		3
12	TOTAL	25	9,150	6,432.00		1,951		3
13	RPCH VISITS							
15	SKILLED NURSING FACILITY	38	13,908					3,524
24	RURAL HEALTH CLINIC					1,717		
24 01	RURAL HEALTH CLINIC 2					313		
25	TOTAL	63						
26	OBSERVATION BED DAYS							2
27	AMBULANCE TRIPS					230		
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	I/P DAYS / TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS TOTAL OBSERVATION BEDS ADMITTED	TRIPS OBSERVATION BEDS NOT ADMITTED	INTERNS & RES. FTES TOTAL	LESS I&R REPL NON-PHYS ANES
		5.01	5.02	6	6.01	6.02	7	8
1	ADULTS & PEDIATRICS			268				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			1,800				
4	ADULTS & PED-SB NF			1,487				
5	TOTAL ADULTS AND PEDS			3,555				
12	TOTAL			3,555				
13	RPCH VISITS							
15	SKILLED NURSING FACILITY			8,962				
24	RURAL HEALTH CLINIC			17,082				
24 01	RURAL HEALTH CLINIC 2			1,818				
25	TOTAL							
26	OBSERVATION BED DAYS		2	13	1	12		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	I & R FTES NET	FULL TIME EQUIV EMPLOYEES ON PAYROLL	FULL TIME EQUIV NONPAID WORKERS	DISCHARGES TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
		9	10	11	12	13	14	15
1	ADULTS & PEDIATRICS					60	8	109
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		108.75			60	8	109
13	RPCH VISITS							
15	SKILLED NURSING FACILITY		27.58					
24	RURAL HEALTH CLINIC		13.24					
24 01	RURAL HEALTH CLINIC 2		2.90					
25	TOTAL		152.47					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

PROVIDER NO:	PERIOD:	PREPARED 12/ 1/2008
14-1329	FROM 7/ 1/2007	WORKSHEET S-8
COMPONENT NO:	TO 6/30/2008	
14-3981		

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

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 303 JACKSON

1.01 CITY: MORRISON STATE: IL ZIP CODE: 61270 COUNTY: WHITESIDE

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

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	COASTAL PHYSICIANS	14-3981

	PHYSICIAN NAME	HOURS OF SUPERVISION

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

FACILITY HOURS OF OPERATIONS (1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	TYPE OPERATION	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC	800	2000	800	2000	800	2000	800	2000	800	2000	800	2000	800	2000

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

Health Financial Systems MCRIF32 FOR MORRISON COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96 S-8 (09/2000)

	PROVIDER NO:	PERIOD:	PREPARED 12/ 1/2008
PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	14-1329	FROM 7/ 1/2007	WORKSHEET S-8
	COMPONENT NO: 14-3481	TO 6/30/2008	

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 333 CHIGACO AVENUE

1.01 CITY: SAVANNA STATE: IL ZIP CODE: 61074 COUNTY:

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

	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	DUNCAN DINKHA	10003802091
9.01	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	LINDA GRANT	1407806953
9.02	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	ELIA HOEKSTRA	1285716230

		PHYSICIAN NAME	HOURS OF SUPERVISION
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	DUNCAN DINKA	52.00

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	1700	830	1700	830	1700	830	1700	830	1700		

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | I PROVIDER NO: I 14-1329 | I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 | I PREPARED 12/ 1/2008 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT				197,158	197,158
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		459,743	459,743	-110,521	349,222
5	0500	EMPLOYEE BENEFITS		558,726	558,726		558,726
6	0600	ADMINISTRATIVE & GENERAL	310,729	708,806	1,019,535	-43,008	976,527
8	0800	OPERATION OF PLANT	67,839	340,082	407,921		407,921
9	0900	LAUNDRY & LINEN SERVICE		49,406	49,406		49,406
10	1000	HOUSEKEEPING	141,048	35,476	176,524		176,524
11	1100	DIETARY	155,597	124,251	279,848		279,848
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	92,750	1,430	94,180		94,180
17	1700	MEDICAL RECORDS & LIBRARY	84,764	17,326	102,090		102,090
18	1800	SOCIAL SERVICE	47,489	71	47,560		47,560
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	870,988	77,415	948,403	-6,685	941,718
34	3400	SKILLED NURSING FACILITY	566,538	27,438	593,976	-3,646	590,330
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	11,064	49,987	61,051	-68	60,983
40	4000	ANESTHESIOLOGY		35,020	35,020		35,020
41	4100	RADIOLOGY-DIAGNOSTIC	151,760	55,903	207,663	117	207,780
44	4400	LABORATORY	224,877	220,759	445,636	-89,217	356,419
49	4900	RESPIRATORY THERAPY		21,667	21,667	-17,602	4,065
50	5000	PHYSICAL THERAPY	210,402	9,363	219,765	-1,551	218,214
51	5100	OCCUPATIONAL THERAPY	94,161	4,557	98,718		98,718
52	5200	SPEECH PATHOLOGY		1,241	1,241		1,241
53	5300	ELECTROCARDIOLOGY	2,277	3,313	5,590		5,590
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		8,389	8,389	135,254	143,643
56	5600	DRUGS CHARGED TO PATIENTS	100,975	168,874	269,849		269,849
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC					
61	6100	EMERGENCY	263,965	489,823	753,788	-6,499	747,289
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC	421,847	542,346	964,193	3,554	967,747
63.51	6311	RURAL HEALTH CLINIC 2	136,862	73,150	210,012		210,012
		OTHER REIMBURS COST CNTRS					
65	6500	AMBULANCE SERVICES	93,143	47,419	140,562	-5,928	134,634
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		54,033	54,033	-54,033	
90	9000	OTHER CAPITAL RELATED COSTS					
95		SUBTOTALS	4,049,075	4,186,014	8,235,089	-2,675	8,232,414
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
100	7950	RENTAL HOUSE				2,675	2,675
100.01	7951	RENTAL SPACE					
100.02	7952	OTHER NONREIMBURSABLE COST CENTERS					
101		TOTAL	4,049,075	4,186,014	8,235,089	-0-	8,235,089

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | I PROVIDER NO: 14-1329 | I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 | I PREPARED 12/ 1/2008 | WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	-18,511	178,647
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	-733	348,489
5	0500	EMPLOYEE BENEFITS	-796	557,930
6	0600	ADMINISTRATIVE & GENERAL	-59,948	916,579
8	0800	OPERATION OF PLANT		407,921
9	0900	LAUNDRY & LINEN SERVICE		49,406
10	1000	HOUSEKEEPING		176,524
11	1100	DIETARY	-22,463	257,385
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION		94,180
17	1700	MEDICAL RECORDS & LIBRARY	-1,894	100,196
18	1800	SOCIAL SERVICE		47,560
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-483	941,235
34	3400	SKILLED NURSING FACILITY		590,330
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		60,983
40	4000	ANESTHESIOLOGY	-34,567	453
41	4100	RADIOLOGY-DIAGNOSTIC	-1,170	206,610
44	4400	LABORATORY	-28,237	328,182
49	4900	RESPIRATORY THERAPY		4,065
50	5000	PHYSICAL THERAPY		218,214
51	5100	OCCUPATIONAL THERAPY		98,718
52	5200	SPEECH PATHOLOGY		1,241
53	5300	ELECTROCARDIOLOGY	-3,313	2,277
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		143,643
56	5600	DRUGS CHARGED TO PATIENTS	-36,592	233,257
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC		
61	6100	EMERGENCY	-71,522	675,767
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310	RURAL HEALTH CLINIC		967,747
63.51	6311	RURAL HEALTH CLINIC 2		210,012
		OTHER REIMBURS COST CNTRS		
65	6500	AMBULANCE SERVICES	-1,243	133,391
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-281,472	7,950,942
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
100	7950	RENTAL HOUSE		2,675
100.01	7951	RENTAL SPACE		
100.02	7952	OTHER NONREIMBURSABLE COST CENTERS		
101		TOTAL	-281,472	7,953,617

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I NOT A CMS WORKSHEET I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
34	SKILLED NURSING FACILITY	3400	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
63.51	RURAL HEALTH CLINIC 2	6311	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
100	RENTAL HOUSE	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	RENTAL SPACE	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	OTHER NONREIMBURSABLE COST CENTERS	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	INCREASE SALARY	INCREASE OTHER
		1	2	3	4	5
1	RECLASSIFY MEDICAL SUPPLIES COST	A	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		135,254
2						
3						
4						
5						
6						
7						
8						
9						
10	RECLASS CT INTEREST EXPENSE	B	RADIOLOGY-DIAGNOSTIC	41		2,955
11			NEW CAP REL COSTS-BLDG & FIXT	3		45,241
12			ADULTS & PEDIATRICS	25		1,220
13			ADMINISTRATIVE & GENERAL	6		4,617
14	RENTAL HOUSE COSTS	D	RENTAL HOUSE	100		2,675
15	RECLASS PROPERTY INSURANCE	F	NEW CAP REL COSTS-BLDG & FIXT	3		13,403
16			NEW CAP REL COSTS-MVBLE EQUIP	4		8,347
17			NEW CAP REL COSTS-BLDG & FIXT	3		19,646
18			RURAL HEALTH CLINIC	63.50		3,554
19	B&F DEPRECIATION	G	NEW CAP REL COSTS-BLDG & FIXT	3		118,868
36	TOTAL RECLASSIFICATIONS					355,780

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

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	DECREASE SALARY	DECREASE OTHER	A-7 REF
		1	6	7	8	9	10
1	RECLASSIFY MEDICAL SUPPLIES COST	A	ADULTS & PEDIATRICS	25		7,905	
2			SKILLED NURSING FACILITY	34		3,646	
3			OPERATING ROOM	37		68	
4			RADIOLOGY-DIAGNOSTIC	41		2,838	
5			LABORATORY	44		89,217	
6			RESPIRATORY THERAPY	49		17,602	
7			PHYSICAL THERAPY	50		1,551	
8			EMERGENCY	61		6,499	
9			AMBULANCE SERVICES	65		5,928	
10	RECLASS CT INTEREST EXPENSE	B	INTEREST EXPENSE	88		54,033	11
11							11
12							
13							
14	RENTAL HOUSE COSTS	D	ADMINISTRATIVE & GENERAL	6		2,675	9
15	RECLASS PROPERTY INSURANCE	F	ADMINISTRATIVE & GENERAL	6		44,950	12
16							12
17							12
18							
19	B&F DEPRECIATION	G	NEW CAP REL COSTS-MVBLE EQUIP	4		118,868	9
36	TOTAL RECLASSIFICATIONS					355,780	

(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 : RECLASSIFY MEDICAL SUPPLIES COST

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	135,254	ADULTS & PEDIATRICS	25	7,905
2.00			0	SKILLED NURSING FACILITY	34	3,646
3.00			0	OPERATING ROOM	37	68
4.00			0	RADIOLOGY-DIAGNOSTIC	41	2,838
5.00			0	LABORATORY	44	89,217
6.00			0	RESPIRATORY THERAPY	49	17,602
7.00			0	PHYSICAL THERAPY	50	1,551
10.00			0	EMERGENCY	61	6,499
11.00			0	AMBULANCE SERVICES	65	5,928
TOTAL RECLASSIFICATIONS FOR CODE A			135,254			135,254

RECLASS CODE: B
EXPLANATION : RECLASS CT INTEREST EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RADIOLOGY-DIAGNOSTIC	41	2,955	INTEREST EXPENSE	88	54,033
2.00	NEW CAP REL COSTS-BLDG & FIXT	3	45,241			0
3.00	ADULTS & PEDIATRICS	25	1,220			0
4.00	ADMINISTRATIVE & GENERAL	6	4,617			0
TOTAL RECLASSIFICATIONS FOR CODE B			54,033			54,033

RECLASS CODE: D
EXPLANATION : RENTAL HOUSE COSTS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RENTAL HOUSE	100	2,675	ADMINISTRATIVE & GENERAL	6	2,675
TOTAL RECLASSIFICATIONS FOR CODE D			2,675			2,675

RECLASS CODE: F
EXPLANATION : RECLASS PROPERTY INSURANCE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	13,403	ADMINISTRATIVE & GENERAL	6	44,950
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	8,347			0
3.00	NEW CAP REL COSTS-BLDG & FIXT	3	19,646			0
4.00	RURAL HEALTH CLINIC	63.50	3,554			0
TOTAL RECLASSIFICATIONS FOR CODE F			44,950			44,950

RECLASS CODE: G
EXPLANATION : B&F DEPRECIATION

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	118,868	NEW CAP REL COSTS-MVBLE EQUIP	4	118,868
TOTAL RECLASSIFICATIONS FOR CODE G			118,868			118,868

Health Financial Systems MCRIF32 FOR MORRISON COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)
ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL I PROVIDER NO: I PERIOD: I PREPARED 12/ 1/2008
ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE I 14-1329 I FROM 7/ 1/2007 I WORKSHEET A-7
COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS I I TO 6/30/2008 I PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS PURCHASES	ACQUISITIONS DONATION	ACQUISITIONS TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND	21,657					21,657	
2	LAND IMPROVEMENTS	368,128	86,826		86,826		454,954	
3	BUILDINGS & FIXTURE	5,266,362					5,266,362	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	2,607,835	463,177		463,177	53,087	3,017,925	
7	SUBTOTAL	8,263,982	550,003		550,003	53,087	8,760,898	
8	RECONCILING ITEMS							
9	TOTAL	8,263,982	550,003		550,003	53,087	8,760,898	

Health Financial Systems MCRIF32 FOR MORRISON COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(12/1999)
RECONCILIATION OF CAPITAL COSTS CENTERS I PROVIDER NO: I PERIOD: I PREPARED 12/ 1/2008
I 14-1329 I FROM 7/ 1/2007 I WORKSHEET A-7
I I TO 6/30/2008 I PARTS III & IV

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
		GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	87,490		87,490	.237008				
4	NEW CAP REL COSTS-MV	281,653		281,653	.762992				
5	TOTAL	369,143		369,143	1.000000				

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	118,868		26,730	33,049			178,647
4	NEW CAP REL COSTS-MV	340,142			8,347			348,489
5	TOTAL	459,010		26,730	41,396			527,136

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV	459,743						459,743
5	TOTAL	459,743						459,743

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-74,835			
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					
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		OCCUPATIONAL THERAPY	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37	COPY & TRANSCRIPTS	B	-1,833	MEDICAL RECORDS & LIBRARY	17	
38	PHARMACY REFUND & REBATES	B	-33,258	DRUGS CHARGED TO PATIENTS	56	
38.02	CAFETERIA SALES-EMPLOYEE	B	-21,880	DIETARY	11	
38.03	IRS PENALTIES & LATE FEE	A	-596	NEW CAP REL COSTS-BLDG &	3	11
38.04	TELEVISION EQUIPMENT	A	-733	NEW CAP REL COSTS-MVBLE E	4	9
38.05	LAB OTHER REVENUE	B	-28,061	LABORATORY	44	
38.06	PHARMACY EMPLOYEE REVENUE	B	-3,334	DRUGS CHARGED TO PATIENTS	56	
39	ADVERTISING	A	-38,059	ADMINISTRATIVE & GENERAL	6	
40	NONALLOWABLE IHA DUES	A	-3,584	ADMINISTRATIVE & GENERAL	6	
41	OTHER REV -A&G	B	-158	ADMINISTRATIVE & GENERAL	6	
42	OTHER REV -DIETARY	B	-583	DIETARY	11	
43	OTHER REV -MED REC	B	-61	MEDICAL RECORDS & LIBRARY	17	
44	OTHER REV - LAB	B	-176	LABORATORY	44	
45	OTHER REV - AMBULANCE	B	-1,243	AMBULANCE SERVICES	65	
46	CRNA FEES	A	-34,567	ANESTHESIOLOGY	40	
47	PATIENT TELEPHONE - SALARIES	A	-5,766	ADMINISTRATIVE & GENERAL	6	
48	PATIENT TELEPHONE - BENEFITS	A	-796	EMPLOYEE BENEFITS	5	
49	INVESTMENT INCOME-OTHER	B	-1,170	RADIOLOGY-DIAGNOSTIC	41	
49.01	INVESTMENT INCOME-OTHER	B	-17,915	NEW CAP REL COSTS-BLDG &	3	11
49.02	INVESTMENT INCOME-OTHER	B	-483	ADULTS & PEDIATRICS	25	
49.03	INVESTMENT INCOME-OTHER	B	-1,828	ADMINISTRATIVE & GENERAL	6	
49.04	PROPERTY TAXES	A	-2,675	ADMINISTRATIVE & GENERAL	6	
49.05	PENALTY FEE EXPENSE	A	-7,878	ADMINISTRATIVE & GENERAL	6	
50	TOTAL (SUM OF LINES 1 THRU 49)		-281,472			

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 14-1329 I
I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I
I PREPARED 12/ 1/2008 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFES-SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
1	61	ER PHYSICIAN FEES	358,182	71,522	286,660				
2	61	ER MEDICAL DIRECTOR	36,000		36,000				
3	53	EKG PHYSICIAN FEES	3,313	3,313					
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	397,495	74,835	322,660				

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUSTMENT
	10	11	12	13	14	15	16	17	18
1	61	ER PHYSICIAN FEES							71,522
2	61	ER MEDICAL DIRECTOR							
3	53	EKG PHYSICIAN FEES							3,313
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL							74,835

I PROVIDER NO:	I PERIOD:	I PREPARED 12/ 1/2008
I 14-1329	I FROM 7/ 1/2007	I WORKSHEET A-8-4
I	I TO 6/30/2008	I PARTS I - VII

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

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)					
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)					
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)					
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)					
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)					
7	STANDARD TRAVEL EXPENSE RATE					
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					
9	TOTAL HOURS WORKED					
10	AHSEA (SEE INSTRUCTIONS)					
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)					
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

STANDARD TRAVEL ALLOWANCE

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

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

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

PART V - OVERTIME COMPUTATION

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

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

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

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)

67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)

68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)

68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)

68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)

69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)

69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)

69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)

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

I PROVIDER NO: 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	9
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	135
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	12
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.63
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	3.63

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		26.00			
10	AHSEA (SEE INSTRUCTIONS)	80.28	64.22	48.17	32.11	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.11	32.11	24.09		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	1,670
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	1,670
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	1,670

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	64.23
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	8,671
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	8,671

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

STANDARD TRAVEL ALLOWANCE

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	289
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	289
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	44
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	333

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

OCCUPATIONAL THERAPY

33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	333
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	8,671
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	333
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	9,004
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	1,950

65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	
PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES		
66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	1,950
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	1,950
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO: 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I WORKSHEET A-8-4 I PARTS I - VII

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	5
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	75
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	7
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.63
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	3.63

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		7.00			
10	AHSEA (SEE INSTRUCTIONS)	77.14	61.71	46.28	30.86	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	30.86	30.86	23.14		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	432
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	432
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	432

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	61.71
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	4,628
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	4,628

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

STANDARD TRAVEL ALLOWANCE

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	162
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	162
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	25
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	187

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

SPEECH PATHOLOGY

33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	187
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	4,628
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	187
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	4,815
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	1,241

SPEECH PATHOLOGY

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	1,241
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	1,241
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

Health Financial Systems MCRIF32 FOR MORRISON COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1997)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 1/2008
I 14-1329 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET
I I TO 6/30/2008 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR	VALUE	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	-6	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	9	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	3	SQUARE	FEET	ENTERED
11	DIETARY	11	MEALS	SERVED	ENTERED
12	CAFETERIA	12	FTE'S		ENTERED
14	NURSING ADMINISTRATION	14	HOURS OF	SERVICE	ENTERED
17	MEDICAL RECORDS & LIBRARY	C	GROSS	CHARGES	ENTERED
18	SOCIAL SERVICE	18	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET B PART I

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
			0	3	4	5	5a.00	6	8
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	178,647	178,647					
004		NEW CAP REL COSTS-MVBLE E	348,489		348,489				
005		EMPLOYEE BENEFITS	557,930			557,930			
006		ADMINISTRATIVE & GENERAL	916,579	38,194	74,680	42,816	1,072,269	1,072,269	
008		OPERATION OF PLANT	407,921	20,592	833	9,348	438,694	68,359	507,053
009		LAUNDRY & LINEN SERVICE	49,406	2,088			51,494	8,024	8,832
010		HOUSEKEEPING	176,524	3,867		19,435	199,826	31,137	16,359
011		DIETARY	257,385	3,940	675	21,440	283,440	44,166	16,669
012		CAFETERIA		1,630			1,630	254	6,897
014		NURSING ADMINISTRATION	94,180			12,780	106,960	16,667	
017		MEDICAL RECORDS & LIBRARY	100,196	3,047	3,207	11,680	118,130	18,407	12,888
018		SOCIAL SERVICE	47,560	1,521		6,544	55,625	8,668	6,433
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	941,235	26,988	45,419	120,015	1,133,657	176,646	114,171
034		SKILLED NURSING FACILITY	590,330	28,459	2,715	78,064	699,568	109,009	120,393
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	60,983	7,818	213	1,525	70,539	10,992	33,072
040		ANESTHESIOLOGY	453				453	71	
041		RADIOLOGY-DIAGNOSTIC	206,610	3,778	144,946	20,911	376,245	58,628	15,983
044		LABORATORY	328,182	4,358	22,775	30,986	386,301	60,195	18,437
049		RESPIRATORY THERAPY	4,065				4,065	633	
050		PHYSICAL THERAPY	218,214	5,288	331	28,992	252,825	39,396	22,372
051		OCCUPATIONAL THERAPY	98,718	1,568	97	12,975	113,358	17,664	6,632
052		SPEECH PATHOLOGY	1,241				1,241	193	
053		ELECTROCARDIOLOGY	2,277			314	2,591	404	
055		MEDICAL SUPPLIES CHARGED	143,643	4,531			148,174	23,089	19,167
056		DRUGS CHARGED TO PATIENTS	233,257	1,325	5,466	13,914	253,962	39,573	5,604
		OUTPAT SERVICE COST CNTRS							
060		CLINIC							
061		EMERGENCY	675,767	1,667	614	36,372	714,420	111,323	7,052
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	967,747	8,884	29,612	58,127	1,064,370	165,853	37,582
063	51	RURAL HEALTH CLINIC 2	210,012			18,858	228,870	35,663	
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	133,391	2,825	16,906	12,834	165,956	25,860	11,949
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	7,950,942	172,368	348,489	557,930	7,944,663	1,070,874	480,492
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP		988			988	154	4,178
100		RENTAL HOUSE	2,675				2,675	417	
100	01	RENTAL SPACE		5,291			5,291	824	22,383
100	02	OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	7,953,617	178,647	348,489	557,930	7,953,617	1,072,269	507,053

		COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
			9	10	11	12	14	17	18
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
008		OPERATION OF PLANT							
009		LAUNDRY & LINEN SERVICE	68,350						
010		HOUSEKEEPING		247,322					
011		DIETARY		8,555	352,830				
012		CAFETERIA		3,540	72,002	84,323			
014		NURSING ADMINISTRATION				1,407	125,034		
017		MEDICAL RECORDS & LIBRARY		6,615		2,762		158,802	
018		SOCIAL SERVICE		3,302		740			74,768
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	15,627	58,600	78,906	22,850	88,198	17,551	47,466
034		SKILLED NURSING FACILITY	48,497	61,792	201,922	20,205		21,826	24,268
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM		16,975		147	570	5,154	
040		ANESTHESIOLOGY						379	
041		RADIOLOGY-DIAGNOSTIC	840	8,204		4,813		16,453	
044		LABORATORY		9,463		5,626		16,767	
049		RESPIRATORY THERAPY						2,679	
050		PHYSICAL THERAPY	853	11,483		2,234		11,559	
051		OCCUPATIONAL THERAPY		3,404		740		6,199	
052		SPEECH PATHOLOGY						19	
053		ELECTROCARDIOLOGY						406	
055		MEDICAL SUPPLIES CHARGED		9,838				4,761	
056		DRUGS CHARGED TO PATIENTS		2,876		1,304		11,922	
		OUTPAT SERVICE COST CNTRS							
060		CLINIC							
061		EMERGENCY	1,475	3,620		9,392	36,266	9,302	3,034
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	874	19,289		9,700		25,920	
063	51	RURAL HEALTH CLINIC 2						2,637	
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	184	6,133		2,403		5,268	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	68,350	233,689	352,830	84,323	125,034	158,802	74,768
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP		2,145					
100		RENTAL HOUSE							
100	01	RENTAL SPACE		11,488					
100	02	OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	68,350	247,322	352,830	84,323	125,034	158,802	74,768

		COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
			25	26	27
		GENERAL SERVICE COST CNTR			
003		NEW CAP REL COSTS-BLDG &			
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			
018		SOCIAL SERVICE			
		INPAT ROUTINE SRVC CNTRS			
025		ADULTS & PEDIATRICS	1,753,672		1,753,672
034		SKILLED NURSING FACILITY	1,307,480		1,307,480
		ANCILLARY SRVC COST CNTRS			
037		OPERATING ROOM	137,449		137,449
040		ANESTHESIOLOGY	903		903
041		RADIOLOGY-DIAGNOSTIC	481,166		481,166
044		LABORATORY	496,789		496,789
049		RESPIRATORY THERAPY	7,377		7,377
050		PHYSICAL THERAPY	340,722		340,722
051		OCCUPATIONAL THERAPY	147,997		147,997
052		SPEECH PATHOLOGY	1,453		1,453
053		ELECTROCARDIOLOGY	3,401		3,401
055		MEDICAL SUPPLIES CHARGED	205,029		205,029
056		DRUGS CHARGED TO PATIENTS	315,241		315,241
		OUTPAT SERVICE COST CNTRS			
060		CLINIC			
061		EMERGENCY	895,884		895,884
062		OBSERVATION BEDS (NON-DIS			
063		OTHER OUTPATIENT SERVICE			
063	50	RURAL HEALTH CLINIC	1,323,588		1,323,588
063	51	RURAL HEALTH CLINIC 2	267,170		267,170
		OTHER REIMBURS COST CNTRS			
065		AMBULANCE SERVICES	217,753		217,753
		SPEC PURPOSE COST CENTERS			
095		SUBTOTALS	7,903,074		7,903,074
		NONREIMBURS COST CENTERS			
096		GIFT, FLOWER, COFFEE SHOP	7,465		7,465
100		RENTAL HOUSE	3,092		3,092
100	01	RENTAL SPACE	39,986		39,986
100	02	OTHER NONREIMBURSABLE COS			
101		CROSS FOOT ADJUSTMENT			
102		NEGATIVE COST CENTER			
103		TOTAL	7,953,617		7,953,617

ALLOCATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET B PART III

		COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
			0	3	4	4a	5	6	8
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL	6,319	38,194	74,680	119,193		119,193	
008		OPERATION OF PLANT		20,592	833	21,425		7,599	29,024
009		LAUNDRY & LINEN SERVICE		2,088		2,088		892	506
010		HOUSEKEEPING		3,867		3,867		3,461	936
011		DIETARY	720	3,940	675	5,335		4,909	954
012		CAFETERIA		1,630		1,630		28	395
014		NURSING ADMINISTRATION						1,853	
017		MEDICAL RECORDS & LIBRARY		3,047	3,207	6,254		2,046	738
018		SOCIAL SERVICE		1,521		1,521		963	368
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,075	26,988	45,419	73,482		19,639	6,535
034		SKILLED NURSING FACILITY		28,459	2,715	31,174		12,117	6,891
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	2,600	7,818	213	10,631		1,222	1,893
040		ANESTHESIOLOGY						8	
041		RADIOLOGY-DIAGNOSTIC		3,778	144,946	148,724		6,517	915
044		LABORATORY		4,358	22,775	27,133		6,691	1,055
049		RESPIRATORY THERAPY	4,065			4,065		70	
050		PHYSICAL THERAPY		5,288	331	5,619		4,379	1,281
051		OCCUPATIONAL THERAPY		1,568	97	1,665		1,963	380
052		SPEECH PATHOLOGY						21	
053		ELECTROCARDIOLOGY						45	
055		MEDICAL SUPPLIES CHARGED		4,531		4,531		2,567	1,097
056		DRUGS CHARGED TO PATIENTS		1,325	5,466	6,791		4,399	321
		OUTPAT SERVICE COST CNTRS							
060		CLINIC							
061		EMERGENCY		1,667	614	2,281		12,374	404
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	68	8,884	29,612	38,564		18,436	2,151
063	51	RURAL HEALTH CLINIC 2						3,964	
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES		2,825	16,906	19,731		2,875	684
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	14,847	172,368	348,489	535,704		119,038	27,504
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP		988		988		17	239
100		RENTAL HOUSE						46	
100	01	RENTAL SPACE		5,291		5,291		92	1,281
100	02	OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	14,847	178,647	348,489	541,983		119,193	29,024

		COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
			9	10	11	12	14	17	18
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
008		OPERATION OF PLANT							
009		LAUNDRY & LINEN SERVICE	3,486						
010		HOUSEKEEPING		8,264					
011		DIETARY		286	11,484				
012		CAFETERIA		118	2,344	4,515			
014		NURSING ADMINISTRATION				75	1,928		
017		MEDICAL RECORDS & LIBRARY		221		148		9,407	
018		SOCIAL SERVICE		110		40			3,002
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	797	1,958	2,568	1,222	1,360	1,039	1,906
034		SKILLED NURSING FACILITY	2,473	2,064	6,572	1,082		1,292	974
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM		567		8	9	305	
040		ANESTHESIOLOGY						22	
041		RADIOLOGY-DIAGNOSTIC	43	274		258		974	
044		LABORATORY		316		301		993	
049		RESPIRATORY THERAPY						159	
050		PHYSICAL THERAPY	44	384		120		684	
051		OCCUPATIONAL THERAPY		114		40		367	
052		SPEECH PATHOLOGY						1	
053		ELECTROCARDIOLOGY						24	
055		MEDICAL SUPPLIES CHARGED		329				282	
056		DRUGS CHARGED TO PATIENTS		96		70		706	
		OUTPAT SERVICE COST CNTRS							
060		CLINIC							
061		EMERGENCY	75	121		503	559	551	122
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	45	645		519		1,540	
063	51	RURAL HEALTH CLINIC 2						156	
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	9	205		129		312	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	3,486	7,808	11,484	4,515	1,928	9,407	3,002
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP		72					
100		RENTAL HOUSE							
100	01	RENTAL SPACE		384					
100	02	OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	3,486	8,264	11,484	4,515	1,928	9,407	3,002

ALLOCATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET B PART III

		COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
			25	26	27
		GENERAL SERVICE COST CNTR			
003		NEW CAP REL COSTS-BLDG &			
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			
018		SOCIAL SERVICE			
		INPAT ROUTINE SRVC CNTRS			
025		ADULTS & PEDIATRICS	110,506		110,506
034		SKILLED NURSING FACILITY	64,639		64,639
		ANCILLARY SRVC COST CNTRS			
037		OPERATING ROOM	14,635		14,635
040		ANESTHESIOLOGY	30		30
041		RADIOLOGY-DIAGNOSTIC	157,705		157,705
044		LABORATORY	36,489		36,489
049		RESPIRATORY THERAPY	4,294		4,294
050		PHYSICAL THERAPY	12,511		12,511
051		OCCUPATIONAL THERAPY	4,529		4,529
052		SPEECH PATHOLOGY	22		22
053		ELECTROCARDIOLOGY	69		69
055		MEDICAL SUPPLIES CHARGED	8,806		8,806
056		DRUGS CHARGED TO PATIENTS	12,383		12,383
		OUTPAT SERVICE COST CNTRS			
060		CLINIC			
061		EMERGENCY	16,990		16,990
062		OBSERVATION BEDS (NON-DIS			
063		OTHER OUTPATIENT SERVICE			
063	50	RURAL HEALTH CLINIC	61,900		61,900
063	51	RURAL HEALTH CLINIC 2	4,120		4,120
		OTHER REIMBURS COST CNTRS			
065		AMBULANCE SERVICES	23,945		23,945
		SPEC PURPOSE COST CENTERS			
095		SUBTOTALS	533,573		533,573
		NONREIMBURS COST CENTERS			
096		GIFT, FLOWER, COFFEE SHOP	1,316		1,316
100		RENTAL HOUSE	46		46
100	01	RENTAL SPACE	7,048		7,048
100	02	OTHER NONREIMBURSABLE COS			
101		CROSS FOOT ADJUSTMENTS			
102		NEGATIVE COST CENTER			
103		TOTAL	541,983		541,983

COST ALLOCATION - STATISTICAL BASIS | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET B-1

		COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE E (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)
			3	4	5	6a.00	6	8
		GENERAL SERVICE COST						
003		NEW CAP REL COSTS-BLD	68,372					
004		NEW CAP REL COSTS-MVB		338,929				
005		EMPLOYEE BENEFITS			4,049,075			
006		ADMINISTRATIVE & GENE	14,618	72,631	310,729	-1,072,269	6,881,348	
008		OPERATION OF PLANT	7,881	810	67,839		438,694	45,873
009		LAUNDRY & LINEN SERVI	799				51,494	799
010		HOUSEKEEPING	1,480		141,048		199,826	1,480
011		DIETARY	1,508	656	155,597		283,440	1,508
012		CAFETERIA	624				1,630	624
014		NURSING ADMINISTRATIO			92,750		106,960	
017		MEDICAL RECORDS & LIB	1,166	3,119	84,764		118,130	1,166
018		SOCIAL SERVICE	582		47,489		55,625	582
		INPAT ROUTINE SRVC CN						
025		ADULTS & PEDIATRICS	10,329	44,173	870,988		1,133,657	10,329
034		SKILLED NURSING FACIL	10,892	2,641	566,538		699,568	10,892
		ANCILLARY SRVC COST C						
037		OPERATING ROOM	2,992	207	11,064		70,539	2,992
040		ANESTHESIOLOGY					453	
041		RADIOLOGY-DIAGNOSTIC	1,446	140,971	151,760		376,245	1,446
044		LABORATORY	1,668	22,150	224,877		386,301	1,668
049		RESPIRATORY THERAPY					4,065	
050		PHYSICAL THERAPY	2,024	322	210,402		252,825	2,024
051		OCCUPATIONAL THERAPY	600	94	94,161		113,358	600
052		SPEECH PATHOLOGY					1,241	
053		ELECTROCARDIOLOGY			2,277		2,591	
055		MEDICAL SUPPLIES CHAR	1,734				148,174	1,734
056		DRUGS CHARGED TO PATI	507	5,316	100,975		253,962	507
		OUTPAT SERVICE COST C						
060		CLINIC						
061		EMERGENCY	638	597	263,965		714,420	638
062		OBSERVATION BEDS (NON						
063		OTHER OUTPATIENT SERV						
063	50	RURAL HEALTH CLINIC	3,400	28,800	421,847		1,064,370	3,400
063	51	RURAL HEALTH CLINIC 2			136,862		228,870	
		OTHER REIMBURS COST C						
065		AMBULANCE SERVICES	1,081	16,442	93,143		165,956	1,081
		SPEC PURPOSE COST CEN						
095		SUBTOTALS	65,969	338,929	4,049,075	-1,072,269	6,872,394	43,470
		NONREIMBURS COST CENT						
096		GIFT, FLOWER, COFFEE	378				988	378
100		RENTAL HOUSE					2,675	
100	01	RENTAL SPACE	2,025				5,291	2,025
100	02	OTHER NONREIMBURSABLE						
101		CROSS FOOT ADJUSTMENT						
102		NEGATIVE COST CENTER						
103		COST TO BE ALLOCATED (WRKSHT B, PART I)	178,647	348,489	557,930		1,072,269	507,053
104		UNIT COST MULTIPLIER (WRKSHT B, PT I)	2.612868	1.028206	.137792		.155823	11.053408
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					119,193	29,024
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)					.017321	.632703

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)
		9	10	11	12	14	17	18
	GENERAL SERVICE COST							
003	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	10,012						
010	HOUSEKEEPING		43,594					
011	DIETARY		1,508	50,336				
012	CAFETERIA		624	10,272	11,510			
014	NURSING ADMINISTRATIO				192	91,971		
017	MEDICAL RECORDS & LIB		1,166		377		10,066,867	
018	SOCIAL SERVICE		582		101			419
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	2,289	10,329	11,257	3,119	64,876	1,112,574	266
034	SKILLED NURSING FACIL	7,104	10,892	28,807	2,758		1,383,582	136
	ANCILLARY SRVC COST C							
037	OPERATING ROOM		2,992		20	419	326,716	
040	ANESTHESIOLOGY						24,046	
041	RADIOLOGY-DIAGNOSTIC	123	1,446		657		1,043,003	
044	LABORATORY		1,668		768		1,062,896	
049	RESPIRATORY THERAPY						169,842	
050	PHYSICAL THERAPY	125	2,024		305		732,715	
051	OCCUPATIONAL THERAPY		600		101		392,942	
052	SPEECH PATHOLOGY						1,213	
053	ELECTROCARDIOLOGY						25,746	
055	MEDICAL SUPPLIES CHAR		1,734				301,836	
056	DRUGS CHARGED TO PATI		507		178		755,764	
	OUTPAT SERVICE COST C							
060	CLINIC							
061	EMERGENCY	216	638		1,282	26,676	589,650	17
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063 50	RURAL HEALTH CLINIC	128	3,400		1,324		1,643,214	
063 51	RURAL HEALTH CLINIC 2						167,178	
	OTHER REIMBURS COST C							
065	AMBULANCE SERVICES	27	1,081		328		333,950	
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	10,012	41,191	50,336	11,510	91,971	10,066,867	419
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE		378					
100	RENTAL HOUSE							
100 01	RENTAL SPACE		2,025					
100 02	OTHER NONREIMBURSABLE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	68,350	247,322	352,830	84,323	125,034	158,802	74,768
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	6.826808	5.673304	7.009496	7.326064	1.359494	.015775	178.443914
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	3,486	8,264	11,484	4,515	1,928	9,407	3,002
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.348182	.189567	.228147	.392268	.020963	.000934	7.164678

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET C PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	1,753,672		1,753,672		1,753,672
34	SKILLED NURSING FACILITY	1,307,480		1,307,480		1,307,480
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	137,449		137,449		137,449
40	ANESTHESIOLOGY	903		903		903
41	RADIOLOGY-DIAGNOSTIC	481,166		481,166		481,166
44	LABORATORY	496,789		496,789		496,789
49	RESPIRATORY THERAPY	7,377		7,377		7,377
50	PHYSICAL THERAPY	340,722		340,722		340,722
51	OCCUPATIONAL THERAPY	147,997		147,997		147,997
52	SPEECH PATHOLOGY	1,453		1,453		1,453
53	ELECTROCARDIOLOGY	3,401		3,401		3,401
55	MEDICAL SUPPLIES CHARGED	205,029		205,029		205,029
56	DRUGS CHARGED TO PATIENTS	315,241		315,241		315,241
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	895,884		895,884		895,884
62	OBSERVATION BEDS (NON-DIS	10,069		10,069		10,069
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	1,323,588		1,323,588		1,323,588
63 51	RURAL HEALTH CLINIC 2	267,170		267,170		267,170
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	217,753		217,753		217,753
101	SUBTOTAL	7,913,143		7,913,143		7,913,143
102	LESS OBSERVATION BEDS	10,069		10,069		10,069
103	TOTAL	7,903,074		7,903,074		7,903,074

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET C PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	1,087,140		1,087,140			
34		SKILLED NURSING FACILITY	1,383,582		1,383,582			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM		326,716	326,716	.420699	.420699	.420699
40		ANESTHESIOLOGY		24,046	24,046	.037553	.037553	.037553
41		RADIOLOGY-DIAGNOSTIC	36,466	1,006,537	1,043,003	.461328	.461328	.461328
44		LABORATORY	130,380	932,516	1,062,896	.467392	.467392	.467392
49		RESPIRATORY THERAPY	138,434	31,408	169,842	.043434	.043434	.043434
50		PHYSICAL THERAPY	410,384	322,331	732,715	.465013	.465013	.465013
51		OCCUPATIONAL THERAPY	325,398	67,544	392,942	.376638	.376638	.376638
52		SPEECH PATHOLOGY	693	520	1,213	1.197857	1.197857	1.197857
53		ELECTROCARDIOLOGY	2,053	23,693	25,746	.132098	.132098	.132098
55		MEDICAL SUPPLIES CHARGED	212,849	88,987	301,836	.679273	.679273	.679273
56		DRUGS CHARGED TO PATIENTS	504,283	251,481	755,764	.417116	.417116	.417116
		OUTPAT SERVICE COST CNTRS						
60		CLINIC						
61		EMERGENCY	1,955	587,695	589,650	1.519349	1.519349	1.519349
62		OBSERVATION BEDS (NON-DIS		25,434	25,434	.395887	.395887	.395887
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	1,169	1,642,045	1,643,214	.805487	.805487	.805487
63	51	RURAL HEALTH CLINIC 2		167,178	167,178	1.598117	1.598117	1.598117
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES		333,950	333,950	.652053	.652053	.652053
101		SUBTOTAL	4,234,786	5,832,081	10,066,867			
102		LESS OBSERVATION BEDS						
103		TOTAL	4,234,786	5,832,081	10,066,867			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	1,753,672		1,753,672		1,753,672
34	SKILLED NURSING FACILITY	1,307,480		1,307,480		1,307,480
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	137,449		137,449		137,449
40	ANESTHESIOLOGY	903		903		903
41	RADIOLOGY-DIAGNOSTIC	481,166		481,166		481,166
44	LABORATORY	496,789		496,789		496,789
49	RESPIRATORY THERAPY	7,377		7,377		7,377
50	PHYSICAL THERAPY	340,722		340,722		340,722
51	OCCUPATIONAL THERAPY	147,997		147,997		147,997
52	SPEECH PATHOLOGY	1,453		1,453		1,453
53	ELECTROCARDIOLOGY	3,401		3,401		3,401
55	MEDICAL SUPPLIES CHARGED	205,029		205,029		205,029
56	DRUGS CHARGED TO PATIENTS	315,241		315,241		315,241
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	895,884		895,884		895,884
62	OBSERVATION BEDS (NON-DIS	10,069		10,069		10,069
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	1,323,588		1,323,588		1,323,588
63 51	RURAL HEALTH CLINIC 2	267,170		267,170		267,170
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	217,753		217,753		217,753
101	SUBTOTAL	7,913,143		7,913,143		7,913,143
102	LESS OBSERVATION BEDS	10,069		10,069		10,069
103	TOTAL	7,903,074		7,903,074		7,903,074

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,087,140		1,087,140			
34	SKILLED NURSING FACILITY	1,383,582		1,383,582			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM		326,716	326,716	.420699	.420699	.420699
40	ANESTHESIOLOGY		24,046	24,046	.037553	.037553	.037553
41	RADIOLOGY-DIAGNOSTIC	36,466	1,006,537	1,043,003	.461328	.461328	.461328
44	LABORATORY	130,380	932,516	1,062,896	.467392	.467392	.467392
49	RESPIRATORY THERAPY	138,434	31,408	169,842	.043434	.043434	.043434
50	PHYSICAL THERAPY	410,384	322,331	732,715	.465013	.465013	.465013
51	OCCUPATIONAL THERAPY	325,398	67,544	392,942	.376638	.376638	.376638
52	SPEECH PATHOLOGY	693	520	1,213	1.197857	1.197857	1.197857
53	ELECTROCARDIOLOGY	2,053	23,693	25,746	.132098	.132098	.132098
55	MEDICAL SUPPLIES CHARGED	212,849	88,987	301,836	.679273	.679273	.679273
56	DRUGS CHARGED TO PATIENTS	504,283	251,481	755,764	.417116	.417116	.417116
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	1,955	587,695	589,650	1.519349	1.519349	1.519349
62	OBSERVATION BEDS (NON-DIS		25,434	25,434	.395887	.395887	.395887
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC	1,169	1,642,045	1,643,214	.805487	.805487	.805487
63 51	RURAL HEALTH CLINIC 2		167,178	167,178	1.598117	1.598117	1.598117
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		333,950	333,950	.652053	.652053	.652053
101	SUBTOTAL	4,234,786	5,832,081	10,066,867			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,234,786	5,832,081	10,066,867			

WKST A LINE	NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	CAPITAL COST WKST B PT II & III, COL. 27	OPERATING COST NET OF CAPITAL COST	CAPITAL REDUCTION	OPERATING COST REDUCTION AMOUNT	COST NET OF CAP AND OPER COST REDUCTION
			1	2	3	4	5	6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	137,449	14,635	122,814			137,449
40		ANESTHESIOLOGY	903	30	873			903
41		RADIOLOGY-DIAGNOSTIC	481,166	157,705	323,461			481,166
44		LABORATORY	496,789	36,489	460,300			496,789
49		RESPIRATORY THERAPY	7,377	4,294	3,083			7,377
50		PHYSICAL THERAPY	340,722	12,511	328,211			340,722
51		OCCUPATIONAL THERAPY	147,997	4,529	143,468			147,997
52		SPEECH PATHOLOGY	1,453	22	1,431			1,453
53		ELECTROCARDIOLOGY	3,401	69	3,332			3,401
55		MEDICAL SUPPLIES CHARGED	205,029	8,806	196,223			205,029
56		DRUGS CHARGED TO PATIENTS	315,241	12,383	302,858			315,241
		OUTPAT SERVICE COST CNTRS						
60		CLINIC						
61		EMERGENCY	895,884	16,990	878,894			895,884
62		OBSERVATION BEDS (NON-DIS	10,069		10,069			10,069
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	1,323,588	61,900	1,261,688			1,323,588
63	51	RURAL HEALTH CLINIC 2	267,170	4,120	263,050			267,170
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	217,753	23,945	193,808			217,753
101		SUBTOTAL	4,851,991	358,428	4,493,563			4,851,991
102		LESS OBSERVATION BEDS	10,069		10,069			10,069
103		TOTAL	4,841,922	358,428	4,483,494			4,841,922

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	326,716	.420699	.420699
40		ANESTHESIOLOGY	24,046	.037553	.037553
41		RADIOLOGY-DIAGNOSTIC	1,043,003	.461328	.461328
44		LABORATORY	1,062,896	.467392	.467392
49		RESPIRATORY THERAPY	169,842	.043434	.043434
50		PHYSICAL THERAPY	732,715	.465013	.465013
51		OCCUPATIONAL THERAPY	392,942	.376638	.376638
52		SPEECH PATHOLOGY	1,213	1.197857	1.197857
53		ELECTROCARDIOLOGY	25,746	.132098	.132098
55		MEDICAL SUPPLIES CHARGED	301,836	.679273	.679273
56		DRUGS CHARGED TO PATIENTS	755,764	.417116	.417116
		OUTPAT SERVICE COST CNTRS			
60		CLINIC			
61		EMERGENCY	589,650	1.519349	1.519349
62		OBSERVATION BEDS (NON-DIS	25,434	.395887	.395887
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	1,643,214	.805487	.805487
63	51	RURAL HEALTH CLINIC 2	167,178	1.598117	1.598117
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES	333,950	.652053	.652053
101		SUBTOTAL	7,596,145		
102		LESS OBSERVATION BEDS	25,434		
103		TOTAL	7,570,711		

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	CAPITAL COST WKST B PT II & III, COL. 27	OPERATING COST NET OF CAPITAL COST	CAPITAL REDUCTION	OPERATING COST REDUCTION AMOUNT	COST NET OF CAP AND OPER COST REDUCTION
			1	2	3	4	5	6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	137,449	14,635	122,814			137,449
40		ANESTHESIOLOGY	903	30	873			903
41		RADIOLOGY-DIAGNOSTIC	481,166	157,705	323,461			481,166
44		LABORATORY	496,789	36,489	460,300			496,789
49		RESPIRATORY THERAPY	7,377	4,294	3,083			7,377
50		PHYSICAL THERAPY	340,722	12,511	328,211			340,722
51		OCCUPATIONAL THERAPY	147,997	4,529	143,468			147,997
52		SPEECH PATHOLOGY	1,453	22	1,431			1,453
53		ELECTROCARDIOLOGY	3,401	69	3,332			3,401
55		MEDICAL SUPPLIES CHARGED	205,029	8,806	196,223			205,029
56		DRUGS CHARGED TO PATIENTS	315,241	12,383	302,858			315,241
		OUTPAT SERVICE COST CNTRS						
60		CLINIC						
61		EMERGENCY	895,884	16,990	878,894			895,884
62		OBSERVATION BEDS (NON-DIS	10,069		10,069			10,069
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	1,323,588	61,900	1,261,688			1,323,588
63	51	RURAL HEALTH CLINIC 2	267,170	4,120	263,050			267,170
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	217,753	23,945	193,808			217,753
101		SUBTOTAL	4,851,991	358,428	4,493,563			4,851,991
102		LESS OBSERVATION BEDS	10,069		10,069			10,069
103		TOTAL	4,841,922	358,428	4,483,494			4,841,922

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

PROVIDER NO: 14-1329
PERIOD: FROM 7/ 1/2007 TO 6/30/2008

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	326,716	.420699	.420699
40		ANESTHESIOLOGY	24,046	.037553	.037553
41		RADIOLOGY-DIAGNOSTIC	1,043,003	.461328	.461328
44		LABORATORY	1,062,896	.467392	.467392
49		RESPIRATORY THERAPY	169,842	.043434	.043434
50		PHYSICAL THERAPY	732,715	.465013	.465013
51		OCCUPATIONAL THERAPY	392,942	.376638	.376638
52		SPEECH PATHOLOGY	1,213	1.197857	1.197857
53		ELECTROCARDIOLOGY	25,746	.132098	.132098
55		MEDICAL SUPPLIES CHARGED	301,836	.679273	.679273
56		DRUGS CHARGED TO PATIENTS	755,764	.417116	.417116
		OUTPAT SERVICE COST CNTRS			
60		CLINIC			
61		EMERGENCY	589,650	1.519349	1.519349
62		OBSERVATION BEDS (NON-DIS	25,434	.395887	.395887
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	1,643,214	.805487	.805487
63	51	RURAL HEALTH CLINIC 2	167,178	1.598117	1.598117
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES	333,950	.652053	.652053
101		SUBTOTAL	7,596,145		
102		LESS OBSERVATION BEDS	25,434		
103		TOTAL	7,570,711		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I WORKSHEET C I PART III

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	137,449	326,716			
40		ANESTHESIOLOGY	903	24,046			
41		RADIOLOGY-DIAGNOSTIC	481,166	1,043,003			
44		LABORATORY	496,789	1,062,896			
49		RESPIRATORY THERAPY	7,377	169,842			
50		PHYSICAL THERAPY	340,722	732,715			
51		OCCUPATIONAL THERAPY	147,997	392,942			
52		SPEECH PATHOLOGY	1,453	1,213			
53		ELECTROCARDIOLOGY	3,401	25,746			
55		MEDICAL SUPPLIES CHARGED	205,029	301,836			
56		DRUGS CHARGED TO PATIENTS	315,241	755,764			
		OUTPAT SERVICE COST CNTRS					
60		CLINIC					
61		EMERGENCY	895,884	589,650			
62		OBSERVATION BEDS (NON-DIS	10,069	25,434			
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC	1,323,588	1,643,214			
63	51	RURAL HEALTH CLINIC 2	267,170	167,178			
		OTHER REIMBURS COST CNTRS					
65		AMBULANCE SERVICES	217,753	333,950			
101		TOTAL	4,851,991	7,596,145			

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I WORKSHEET C I PART V

WKST A LINE	NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT-PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT-PATIENT COSTS 7
		ANCILLARY SRVC COST CNTRS							
37		OPERATING ROOM	137,449		137,449	326,716			
40		ANESTHESIOLOGY	903		903	24,046			
41		RADIOLOGY-DIAGNOSTIC	481,166		481,166	1,043,003			
44		LABORATORY	496,789		496,789	1,062,896			
49		RESPIRATORY THERAPY	7,377		7,377	169,842			
50		PHYSICAL THERAPY	340,722		340,722	732,715			
51		OCCUPATIONAL THERAPY	147,997		147,997	392,942			
52		SPEECH PATHOLOGY	1,453		1,453	1,213			
53		ELECTROCARDIOLOGY	3,401	3,313	6,714	25,746			
55		MEDICAL SUPPLIES CHARGED	205,029		205,029	301,836			
56		DRUGS CHARGED TO PATIENTS	315,241		315,241	755,764			
		OUTPAT SERVICE COST CNTRS							
60		CLINIC							
61		EMERGENCY	895,884	71,522	967,406	589,650			
62		OBSERVATION BEDS (NON-DIS	10,069		10,069	25,434			
63		OTHER OUTPATIENT SERVICE							
63	50	RURAL HEALTH CLINIC							
63	51	RURAL HEALTH CLINIC 2							
		OTHER REIMBURS COST CNTRS							
65		AMBULANCE SERVICES	217,753		217,753	333,950			
101		TOTAL	3,261,233	74,835	3,336,068	5,785,753			
102		TOTAL OUTPATIENT VISITS							
103		AGGREGATE COST PER VISIT							
104		TITLE V OUTPATIENT VISITS							
105		TITLE XVIII OUTPAT VISITS							
106		TITLE XIX OUTPAT VISITS							
107		TITLE V OUTPAT COSTS							
108		TITLE XVIII OUTPAT COSTS							
109		TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET D PART V | COMPONENT NO: 14-1329

TITLE XVIII, PART B HOSPITAL

(A)	Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9) 1	Cost/Charge Ratio (C, Pt I, col. 9) 1.01	Cost/Charge Ratio (C, Pt II, col. 9) 1.02	Outpatient Ambulatory Surgical Ctr 2	Outpatient Radialogy 3
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.420699		.420699		
40	ANESTHESIOLOGY	.037553		.037553		
41	RADIOLOGY-DIAGNOSTIC	.461328		.461328		
44	LABORATORY	.467392		.467392		
49	RESPIRATORY THERAPY	.043434		.043434		
50	PHYSICAL THERAPY	.465013		.465013		
51	OCCUPATIONAL THERAPY	.376638		.376638		
52	SPEECH PATHOLOGY	1.197857		1.197857		
53	ELECTROCARDIOLOGY	.132098		.132098		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.679273		.679273		
56	DRUGS CHARGED TO PATIENTS	.417116		.417116		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	1.519349		1.519349		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.395887		.395887		
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
63 51	RURAL HEALTH CLINIC 2					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	.652053		.652053		
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET D PART V | COMPONENT NO: 14-1329

TITLE XVIII, PART B HOSPITAL

		Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	Cost Center Description	4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		258,871			
40	ANESTHESIOLOGY		18,675			
41	RADIOLOGY-DIAGNOSTIC		260,196			
44	LABORATORY		273,542			
49	RESPIRATORY THERAPY		10,141			
50	PHYSICAL THERAPY		144,197			
51	OCCUPATIONAL THERAPY		41,011			
52	SPEECH PATHOLOGY		520			
53	ELECTROCARDIOLOGY		11,559			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		42,523			
56	DRUGS CHARGED TO PATIENTS		114,216			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY		196,126			
62	OBSERVATION BEDS (NON-DISTINCT PART)		4,692			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
63 51	RURAL HEALTH CLINIC 2					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		1,376,269			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		1,376,269			

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET D PART V | COMPONENT NO: 14-1329

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	108,907		
40		ANESTHESIOLOGY	701		
41		RADIOLOGY-DIAGNOSTIC	120,036		
44		LABORATORY	127,851		
49		RESPIRATORY THERAPY	440		
50		PHYSICAL THERAPY	67,053		
51		OCCUPATIONAL THERAPY	15,446		
52		SPEECH PATHOLOGY	623		
53		ELECTROCARDIOLOGY	1,527		
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	28,885		
56		DRUGS CHARGED TO PATIENTS	47,641		
		OUTPAT SERVICE COST CNTRS			
60		CLINIC			
61		EMERGENCY	297,984		
62		OBSERVATION BEDS (NON-DISTINCT PART)	1,858		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
63	51	RURAL HEALTH CLINIC 2			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		SUBTOTAL	818,952		
102		CRNA CHARGES			
103		LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104		NET CHARGES	818,952		

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 1/2008
14-1329	FROM 7/ 1/2007	WORKSHEET D
COMPONENT NO:	TO 6/30/2008	PART VI
14-1329		

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.417116
2	PROGRAM VACCINE CHARGES	2,010
3	PROGRAM COSTS	838

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 1/2008
14-1329	FROM 7/ 1/2007	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2008	PART I
14-1329		

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,568
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	281
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	281
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	897
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)	903
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	759
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)	728
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	158
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	897
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)	896
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	95.40
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	95.40
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1,753,672
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	72,409
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	69,451
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,536,032
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	217,640
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	220,026
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	220,026
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.989156
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	783.01
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	217,640

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 1/2008
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COMPONENT NO:	TO 6/30/2008	PART II
14-1329		

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	774.54
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	122,377
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	122,377

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

		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	74,799
49	TOTAL PROGRAM INPATIENT COSTS	197,176
	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)	694,762
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	693,988
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	1,388,750
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 1/2008
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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	13
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	774.52
85	OBSERVATION BED COST	10,069

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 12/ 1/2008
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14-5274		

TITLE XVIII PART A SNF PPS

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	8,962
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,962
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,962
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1,307,480
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,307,480
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,383,582
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,383,582
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.944996
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	154.38
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,307,480

COMPUTATION OF INPATIENT OPERATING COST

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14-5274		

TITLE XVIII PART A SNF PPS

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

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1,307,480
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	145.89
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	64,639
72	PER DIEM CAPITAL-RELATED COSTS	7.21
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

COMPUTATION OF INPATIENT OPERATING COST

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TITLE XIX - I/P SNF OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	8,962
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	8,962
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8,962
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,524
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1,307,480
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,307,480
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,383,582
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,383,582
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.944996
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	154.38
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,307,480

COMPUTATION OF INPATIENT OPERATING COST

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TITLE XIX - I/P SNF OTHER

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

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1,307,480
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	145.89
68	PROGRAM ROUTINE SERVICE COST	514,116
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	514,116
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	64,639
72	PER DIEM CAPITAL-RELATED COSTS	7.21
73	PROGRAM CAPITAL-RELATED COSTS	25,408
74	INPATIENT ROUTINE SERVICE COST	488,708
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	488,708
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	25,408
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	25,408

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 12/ 1/2008 I WORKSHEET D-4 I COMPONENT NO: 14-1329 I I

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.		COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS		110,025	
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.420699		
40		ANESTHESIOLOGY	.037553		
41		RADIOLOGY-DIAGNOSTIC	.461328	7,472	3,447
44		LABORATORY	.467392	37,582	17,566
49		RESPIRATORY THERAPY	.043434	13,609	591
50		PHYSICAL THERAPY	.465013	1,004	467
51		OCCUPATIONAL THERAPY	.376638	280	105
52		SPEECH PATHOLOGY	1.197857		
53		ELECTROCARDIOLOGY	.132098	699	92
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.679273	35,740	24,277
56		DRUGS CHARGED TO PATIENTS	.417116	67,667	28,225
		OUTPAT SERVICE COST CNTRS			
60		CLINIC			
61		EMERGENCY	1.519349	19	29
62		OBSERVATION BEDS (NON-DISTINCT PART)	.395887		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
63	51	RURAL HEALTH CLINIC 2			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		TOTAL		164,072	74,799
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		164,072	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET D-4 | COMPONENT NO: 14-Z329

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			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.420699		
40	ANESTHESIOLOGY	.037553		
41	RADIOLOGY-DIAGNOSTIC	.461328	10,452	4,822
44	LABORATORY	.467392	67,421	31,512
49	RESPIRATORY THERAPY	.043434	40,030	1,739
50	PHYSICAL THERAPY	.465013	371,503	172,754
51	OCCUPATIONAL THERAPY	.376638	295,036	111,122
52	SPEECH PATHOLOGY	1.197857		
53	ELECTROCARDIOLOGY	.132098	736	97
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.679273	83,770	56,903
56	DRUGS CHARGED TO PATIENTS	.417116	257,036	107,214
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	1.519349		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.395887		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
63 51	RURAL HEALTH CLINIC 2			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		1,125,984	486,163
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,125,984	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 12/ 1/2008
14-1329	FROM 7/ 1/2007	WORKSHEET E
COMPONENT NO:	TO 6/30/2008	PART B
14-1329		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	819,790
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)	819,790
	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)	827,988
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	6,110
18.01	CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	220,010
19	SUBTOTAL (SEE INSTRUCTIONS)	601,868
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	601,868
24	PRIMARY PAYER PAYMENTS	20
25	SUBTOTAL	601,848
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	33,160
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	33,160
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	24,697
28	SUBTOTAL	635,008
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	635,008
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	642,134
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-7,126
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:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2007	12/ 1/2008
COMPONENT NO:	TO 6/30/2008	WORKSHEET E-1
14-1329		

TITLE XVIII HOSPITAL

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			168,894		642,134
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS			168,894		642,134
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02				
7	TOTAL MEDICARE PROGRAM LIABILITY					

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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(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.

Health Financial Systems MCRIF32 FOR MORRISON COMMUNITY HOSPITAL IN LIEU OF FORM CMS-2552-96 (11/1998)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2007	WORKSHEET E-1
COMPONENT NO:	TO 6/30/2008	
14-Z329		

TITLE XVIII SWING BED SNF

	DESCRIPTION			INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,648,114		
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	2/ 1/2008	80,000		
		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		80,000		NONE
4	TOTAL INTERIM PAYMENTS				1,728,114		
	TO BE COMPLETED BY INTERMEDIARY						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)	TENTATIVE TO PROVIDER	.01				
		TENTATIVE TO PROVIDER	.02				
		TENTATIVE TO PROVIDER	.03				
		TENTATIVE TO PROGRAM	.50				
		TENTATIVE TO PROGRAM	.51				
		TENTATIVE TO PROGRAM	.52				
	SUBTOTAL		.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01				
		SETTLEMENT TO PROGRAM	.02				
7	TOTAL MEDICARE PROGRAM LIABILITY						

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

---

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2007	
COMPONENT NO:	TO 6/30/2008	WORKSHEET E-2
14-Z329		

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)	1,402,638	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	491,025	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	1,793	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,893,663	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,893,663	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,893,663	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	50,880	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,842,783	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,842,783	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,728,114	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	114,669	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 12/ 1/2008
14-1329	FROM 7/ 1/2007	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2008	PART II
14-1329		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT

HOSPITAL

1	INPATIENT SERVICES	197,176
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	197,176
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	199,148
	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	199,148
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	37,972
21	EXCESS REASONABLE COST	
22	SUBTOTAL	161,176
23	COINSURANCE	
24	SUBTOTAL	161,176
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	5,157
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	5,157
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	5,143
26	SUBTOTAL	166,333
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	166,333
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	168,894
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-2,561
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	667,175			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	1,798,634			
5	OTHER RECEIVABLES	677,144			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	141,924			
8	PREPAID EXPENSES	59,556			
9	OTHER CURRENT ASSETS	75,653			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	3,420,086			
	FIXED ASSETS				
12	LAND	108,483			
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	2,190,877			
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	2,299,360			
	OTHER ASSETS				
22	INVESTMENTS	523,734			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS	523,734			
27	TOTAL ASSETS	6,243,180			

BALANCE SHEET | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET G

	LIABILITIES AND FUND BALANCE	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	327,267			
29	SALARIES, WAGES & FEES PAYABLE	220,319			
30	PAYROLL TAXES PAYABLE	107,635			
31	NOTES AND LOANS PAYABLE (SHORT TERM)	152,214			
32	DEFERRED INCOME	350,000			
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES				
36	TOTAL CURRENT LIABILITIES	1,157,435			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE				
38	NOTES PAYABLE	879,357			
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	879,357			
43	TOTAL LIABILITIES	2,036,792			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	4,206,388			
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	4,206,388			
52	TOTAL LIABILITIES AND FUND BALANCES	6,243,180			

STATEMENT OF CHANGES IN FUND BALANCES | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET G-1

		GENERAL FUND	SPECIFIC PURPOSE FUND
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD	3,232,655	
2	NET INCOME (LOSS)	973,727	
3	TOTAL	4,206,382	
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
4	ADDITIONS (CREDIT ADJUSTM		
5	ROUNDING 6		
6			
7			
8			
9			
10	TOTAL ADDITIONS	6	
11	SUBTOTAL	4,206,388	
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
12	DEDUCTIONS (DEBIT ADJUSTM		
13			
14			
15			
16			
17			
18	TOTAL DEDUCTIONS		
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	4,206,388	

		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	ADDITIONS (CREDIT ADJUSTM		
5	ROUNDING		
6			
7			
8			
9			
10	TOTAL ADDITIONS		
11	SUBTOTAL		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
12	DEDUCTIONS (DEBIT ADJUSTM		
13			
14			
15			
16			
17			
18	TOTAL DEDUCTIONS		
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET G-2 | PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL
			1	2	3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	220,026		220,026
4	00	SWING BED - SNF	714,046		714,046
5	00	SWING BED - NF	197,546		197,546
6	00	SKILLED NURSING FACILITY	1,383,582		1,383,582
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	2,515,200		2,515,200
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	2,515,200		2,515,200
17	00	ANCILLARY SERVICES	1,723,235	4,100,972	5,824,207
18	00	OUTPATIENT SERVICES			
18	50	RURAL HEALTH CLINIC		1,642,045	1,642,045
18	51	RURAL HEALTH CLINIC 2		167,178	167,178
20	00	AMBULANCE SERVICES		333,950	333,950
24	00	PROFESSIONAL FEES		6,878	6,878
24	01	ROUNDING		3	3
24	02				
25	00	TOTAL PATIENT REVENUES	4,238,435	6,251,026	10,489,461

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES	8,235,089
		ADD (SPECIFY)	
27	00	ADD (SPECIFY)	
28	00		
29	00		
30	00		
31	00		
32	00		
33	00	TOTAL ADDITIONS	
		DEDUCT (SPECIFY)	
34	00	DEDUCT (SPECIFY)	
35	00		
36	00		
37	00		
38	00		
39	00	TOTAL DEDUCTIONS	
40	00	TOTAL OPERATING EXPENSES	8,235,089

STATEMENT OF REVENUES AND EXPENSES | PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	10,489,461
2	LESS: ALLOWANCES AND DISCOUNTS ON	1,877,539
3	NET PATIENT REVENUES	8,611,922
4	LESS: TOTAL OPERATING EXPENSES	8,235,089
5	NET INCOME FROM SERVICE TO PATIENT	376,833
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	3,403
7	INCOME FROM INVESTMENTS	39,041
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS,FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER OP REV	360,501
24.01	COUNTY TAX	710,173
24.02	STATE TAX	101,399
25	TOTAL OTHER INCOME	1,214,517
26	TOTAL	1,591,350
	OTHER EXPENSES	
27	BAD DEBTS	574,879
28	CHARITY CARE	42,744
29		
30	TOTAL OTHER EXPENSES	617,623
31	NET INCOME (OR LOSS) FOR THE PERIO	973,727

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

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2007	12/ 1/2008
COMPONENT NO:	TO 6/30/2008	WORKSHEET M-1
14-3981		

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN				
2	PHYSICIAN ASSISTANT				
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	421,848		421,848	3,554
10	SUBTOTAL (SUM OF LINES 1-9)	421,848		421,848	3,554
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT		397,495	397,495	
12	PHYSICIAN SUPERVISION UNDER AGREEMENT				
13	OTHER COSTS UNDER AGREEMENT		799	799	
14	SUBTOTAL (SUM OF LINES 11-13)		398,294	398,294	
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		10,932	10,932	
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE		73,356	73,356	
19	OTHER HEALTH CARE COSTS				
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		84,288	84,288	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	421,848	482,582	904,430	3,554
	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		1,711	1,711	
30	ADMINISTRATIVE COSTS		58,052	58,052	
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		59,763	59,763	
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	421,848	542,345	964,193	3,554

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

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2007	12/ 1/2008
COMPONENT NO:	TO 6/30/2008	WORKSHEET M-1
14-3981		

RHC 1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN			
2	PHYSICIAN ASSISTANT			
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	425,402		425,402
10	SUBTOTAL (SUM OF LINES 1-9)	425,402		425,402
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT	397,495		397,495
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT	799		799
14	SUBTOTAL (SUM OF LINES 11-13)	398,294		398,294
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	10,932		10,932
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE	73,356		73,356
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	84,288		84,288
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	907,984		907,984
	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	1,711		1,711
30	ADMINISTRATIVE COSTS	58,052		58,052
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	59,763		59,763
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	967,747		967,747

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

PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET M-1
COMPONENT NO: 14-3481

RHC 2

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN		5,182	5,182	
2	PHYSICIAN ASSISTANT				
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	136,863	22,887	159,750	
10	SUBTOTAL (SUM OF LINES 1-9)	136,863	28,069	164,932	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT				
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)				
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		212	212	
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS				
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		212	212	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	136,863	28,281	165,144	
	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		17,337	17,337	
30	ADMINISTRATIVE COSTS		27,531	27,531	
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		44,868	44,868	
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	136,863	73,149	210,012	

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

PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET M-1

COMPONENT NO: 14-3481

RHC 2

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	5,182		5,182
2	PHYSICIAN ASSISTANT			
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	159,750		159,750
10	SUBTOTAL (SUM OF LINES 1-9)	164,932		164,932
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	212		212
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	212		212
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	165,144		165,144
	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	17,337		17,337
30	ADMINISTRATIVE COSTS	27,531		27,531
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	44,868		44,868
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	210,012		210,012

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

I PROVIDER NO: 14-1329 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I COMPONENT NO: 14-3981 I PREPARED 12/ 1/2008 I WORKSHEET M-2

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	1.01	2,761	2,100	2,121
3	NURSE PRACTITIONERS			2,100	
4	SUBTOTAL (SUM OF LINES 1-3)	1.01	2,761		2,121
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.01	2,761		
9	PHYSICIAN SERVICES UNDER AGREEMENTS		14,321		

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	907,984
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)	907,984
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)	59,763
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	355,841
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	415,604
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	415,604
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	415,604
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,323,588

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	2,761
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2,761
9	PHYSICIAN SERVICES UNDER AGREEMENTS	14,321

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

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

PROVIDER NO: 14-1329 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 12/ 1/2008 | WORKSHEET M-2

COMPONENT NO: 14-3481

RHC 2

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			2,100	
3	NURSE PRACTITIONERS	1.00	1,818	2,100	2,100
4	SUBTOTAL (SUM OF LINES 1-3)	1.00	1,818		2,100
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.00	1,818		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	165,144
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)	165,144
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)	44,868
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	57,158
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	102,026
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	102,026
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	102,026
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	267,170

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	2,100
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2,100
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2007	12/ 1/2008
COMPONENT NO:	TO 6/30/2008	WORKSHEET M-3
14-3981		

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)	1,323,588		
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)			
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,323,588		
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	2,761		
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	14,321		
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	17,082		
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	77.48		
		CALCULATION OF LIMIT (1)		
		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2	
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	74.29	75.63	
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	77.48	77.48	
	CALCULATION OF SETTLEMENT			
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	859	858	
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	66,555	66,478	
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)*		133,033	
16.01	PRIMARY PAYER AMOUNT		261	
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		22,414	
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		110,358	
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		88,286	
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)			
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		88,286	
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			
23	NET REIMBURSABLE AMOUNT			
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		88,286	
25	INTERIM PAYMENTS		93,868	
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		-5,582	
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2			

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2007	12/ 1/2008
COMPONENT NO:	TO 6/30/2008	WORKSHEET M-3
14-3481		

TITLE XVIII RHC 2

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES UCATION PASS THROUGH COST.

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	267,170
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	267,170
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	2,100
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,100
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	127.22

CALCULATION OF LIMIT (1)

		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	74.29	75.63
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	127.22	127.22
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	156	157
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	19,846	19,974
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)*		39,820
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		5,337
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		34,483
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		27,586
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		27,586
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		27,586
25	INTERIM PAYMENTS		17,630
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		9,956
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

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

[X] RHC [ ] FQHC

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2007	12/ 1/2008
COMPONENT NO:	TO 6/30/2008	WORKSHEET M-5
14-3981		

RHC 1

	DESCRIPTION		PART B MM/DD/YYYY (1)	PART B AMOUNT (2)
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			93,868
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		
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		NONE
4	TOTAL INTERIM PAYMENTS			93,868
	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:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

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

[X] RHC [ ] FQHC

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2007	WORKSHEET M-5
COMPONENT NO:	TO 6/30/2008	
14-3481		

RHC 2

	DESCRIPTION		PART B MM/DD/YYYY (1)	PART B AMOUNT (2)
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			17,630
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		
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		NONE
4	TOTAL INTERIM PAYMENTS			17,630
	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:

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.