

WORKSHEET S
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	14-1333	I	FROM 3/ 1/2007	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 2/29/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 0/ 0/0000 TIME 12:00

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:

SARAH D CULBERTSON 14-1333

FOR THE COST REPORTING PERIOD BEGINNING 3/ 1/2007 AND ENDING 2/29/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1 HOSPITAL	0		148,398		-24,415	0
3 SWING BED - SNF	0		97,323		0	0
9 RHC	0		0		233,168	0
9 .01 RHC II	0		0		0	0
9 .02 RHC III	0		0		0	0
100 TOTAL	0		245,721		208,753	0

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 238 SOUTH CONGRESS P.O. BOX:
 1.01 CITY: RUSHVILLE STATE: IL ZIP CODE: 62681- COUNTY: SCHUYLER

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:				DATE			PAYMENT SYSTEM		
COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	CERTIFIED	(P, T, O OR N)	V	XVIII	XIX	
0	1	2	2.01	3	4	5	6		
02.00	HOSPITAL	SARAH D CULBERTSON	14-1333	5/1/2004	N	0	N		
04.00	SWING BED - SNF	SDCMH SWING BED- SNF	14-Z333	5/1/2004	N	0	N		
14.00	HOSPITAL-BASED RHC	BEARDSTOWN CLINIC 1	14-3483	10/1/2006	N	0	N		
14.01	HOSPITAL-BASED RHC 2	COMMUNITY MEDICAL CLINIC	14-3484	10/1/2006	N	0	N		
14.02	HOSPITAL-BASED RHC 3	BEARDSTOWN CLINIC 2	14-3480	4/5/2006	N	0	N		

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 3/1/2007 TO: 2/29/2008 1 2
 18 TYPE OF CONTROL 11

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 42.105 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?
 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN OR (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2
 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN OR (2) RURAL. 2
 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN OR (2) RURAL. 2
 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. N
 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION DATE / /
 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2.
 25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N
 25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-1, CHAPTER 4?
 25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.
 25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-1, 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 5/1/2004

28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y". IF "N" COMPLETE LINES 28.01 AND 28.02				
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)		1	2	3
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	0.0000	0.0000
	A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)		%	Y/N	
28.03	STAFFING		0.00%		
28.04	RECRUITMENT		0.00%		
28.05	RETENTION		0.00%		
28.06	TRAINING		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).	Y			
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
	MISCELLANEOUS COST REPORT INFORMATION				
32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N			
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N			
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N			
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
	PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		V	XVIII	XIX
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	I	2	3	
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N	
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N	
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N	

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

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

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

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

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

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 88,288
 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	FEE\$ 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). N 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

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	25	9,150	23,776.00			721	54
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						594	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	9,150				1,315	54
12 TOTAL	25	9,150				1,315	54
13 RPCH VISITS							
17 OTHER LONG TERM CARE	26	9,516					
24 RURAL HEALTH CLINIC						5,489	
25 TOTAL	51						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX OBSERVATION ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS / TOTAL ALL PATS 6	TRIPS TOTAL OBSERVATION ADMITTED 6.01	DISCHARGES / NOT ADMITTED 6.02	INTERNS & RES. TOTAL 7	FTES LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			1,005				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			594				
4 ADULTS & PED-SB NF			45				
5 TOTAL ADULTS AND PEDS			1,644				
12 TOTAL			1,644				
13 RPCH VISITS							
17 OTHER LONG TERM CARE			8,311				
24 RURAL HEALTH CLINIC			17,296				
25 TOTAL							
26 OBSERVATION BED DAYS			389		389		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET 9	FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					221	28	349
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		125.59			221	28	349
13 RPCH VISITS							
17 OTHER LONG TERM CARE		14.98					
24 RURAL HEALTH CLINIC		20.29					
25 TOTAL		160.86					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET:
 1.01 CITY: STATE: IL ZIP CODE: COUNTY: FULTON/CASS
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	DATE
3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)	1	2
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	MARSHALL ROBERT MD	H11270
9.01 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	CINDY CHAFFIN PA	S44490
9.02 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	SANDY KANTHILAL MD	D09873
9.03 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	JOE FRIDAY PA	P35289
9.04 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	IONUT HRISEA MD	H92565
9.05 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	ABEBE KASSAHUN MD	OTH000
9.06 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DAINEL RAZON	F69262
9.07 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	ZACH SIMS PA	Q38204
9.08 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	JOHN AUGSPURGER MD	A16178
9.09 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	SARA SYEDA MD	I50679

	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	MARSHALL ROBERT MD	40.00
10.01 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	IONUT HRISEA MD	40.00
10.02 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	SEMBU KANMTHIAL	40.00
10.03 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	DANIEL RAZON	40.00

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.) N

FACILITY HOURS OF OPERATIONS (1)

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

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

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

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

15 PROVIDER NAME: COMMUNITY MEDICAL CENTER	PROVIDER NUMBER: 143484
15.01 PROVIDER NAME: BEARDSTOWN CLINIC 1	PROVIDER NUMBER: 143483
15.02 PROVIDER NAME: BEARDSTOWN CLINIC 2	PROVIDER NUMBER: 143480

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

17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR SERVICES RENDERED ON OR AFTER 7/1/2001? IF YES, SEE INSTRUCTIONS.

HOSPITAL UNCOMPENSATED CARE DATA

DESCRIPTION

UNCOMPENSATED CARE INFORMATION	
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04
2.01	IS IT AT THE TIME OF ADMISSION?
2.02	IS IT AT THE TIME OF FIRST BILLING?
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?
2.04	
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?
UNCOMPENSATED CARE REVENUES	
17	REVENUE FROM UNCOMPENSATED CARE 67,484
17.01	GROSS MEDICAID REVENUES 2,554,442
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)
20	RESTRICTED GRANTS
21	NON-RESTRICTED GRANTS
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES 2,621,926
UNCOMPENSATED CARE COST	
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103) .544110
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS
27	TOTAL SCHIP COST (LINE 24 * LINE 26)
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS 2,554,442
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28) 1,389,897
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS 67,484
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30) 36,719
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL 1,389,897 (SUM OF LINES 25, 27, AND 29)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: I 14-1333 I	IN LIEU OF FORM I PERIOD: I FROM 3/1/2007 I TO 2/29/2008 I	CMS-2552-96(9/1996) I PREPARED 7/16/2008 I WORKSHEET A I	
COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		130,415	130,415	18,317	148,732
3.01	0301 NEW CAP REL COSTS-RHCS BLDG/MME				71,481	71,481
3.02	0302 NEW CAP REL COSTS-MED ARTS BLDG/MME		14,680	14,680	205	14,885
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		227,181	227,181	57,558	284,739
5	0500 EMPLOYEE BENEFITS		1,499,947	1,499,947	186,502	1,686,449
6	0600 ADMINISTRATIVE & GENERAL	906,498	1,017,067	1,923,565	2,339	1,925,904
8	0800 OPERATION OF PLANT	188,266	216,890	405,156	3,478	408,634
8.01	0801 PLANT & HSKPG - RHCS				44,356	44,356
10	1000 HOUSEKEEPING	224,550	36,608	261,158		261,158
11	1100 DIETARY	264,347	221,732	486,079	40,718	526,797
12	1200 CAFETERIA					
14	1400 NURSING ADMINISTRATION	135,887	13,567	149,454		149,454
17	1700 MEDICAL RECORDS & LIBRARY	302,255	26,517	328,772	-4,633	324,139
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	649,080	76,533	725,613	-6,283	719,330
36	3600 OTHER LONG TERM CARE	414,989	54,635	469,624	-4,363	465,261
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	126,664	103,519	230,183	-22,376	207,807
40	4000 ANESTHESIOLOGY	224,021	21,626	245,647	-139	245,508
41	4100 RADIOLOGY-DIAGNOSTIC	296,200	559,275	855,475	-1,327	854,148
44	4400 LABORATORY	292,515	485,504	778,019	-5,572	772,447
49	4900 RESPIRATORY THERAPY		88,716	88,716	-4,246	84,470
50	5000 PHYSICAL THERAPY	320,254	57,035	377,289	-16,089	361,200
53	5300 ELECTROCARDIOLOGY	71,912	166,514	238,426	-33	238,393
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	43,896	8,254	52,150	31,040	83,190
56	5600 DRUGS CHARGED TO PATIENTS		695,598	695,598	51,699	747,297
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	30,978	263,144	294,122	-54,360	239,762
61	6100 EMERGENCY	359,966	1,002,971	1,362,937	-5,804	1,357,133
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	854,409	1,218,955	2,073,364	-295,779	1,777,585
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		32,913	32,913	-32,913	
90	9000 OTHER CAPITAL RELATED COSTS					
95	SUBTOTALS	5,706,687	8,239,796	13,946,483	53,776	14,000,259
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
100	7950 SARAH D CULBERTSON GARDENS	137,229	275,969	413,198	-53,776	359,422
100.01	7951 MEDICAL ARTS BUILDING		24,055	24,055		24,055
101	TOTAL	5,843,916	8,539,820	14,383,736	-0-	14,383,736

RECLASSIFICATION AND ADJUSTMENT OF
 TRIAL BALANCE OF EXPENSES

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS- BLDG & FIXT		148,732
3.01	0301 NEW CAP REL COSTS- RHCS BLDG/MME		71,481
3.02	0302 NEW CAP REL COSTS- MED ARTS BLDG/MME		14,885
4	0400 NEW CAP REL COSTS- MVBLE EQUIP		284,739
5	0500 EMPLOYEE BENEFITS	-9,902	1,676,547
6	0600 ADMINISTRATIVE & GENERAL	-54,741	1,871,163
8	0800 OPERATION OF PLANT		408,634
8.01	0801 PLANT & HSKPG - RHCS		44,356
10	1000 HOUSEKEEPING		261,158
11	1100 DIETARY	-73,609	453,188
12	1200 CAFETERIA		
14	1400 NURSING ADMINISTRATION		149,454
17	1700 MEDICAL RECORDS & LIBRARY	-7,623	316,516
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		719,330
36	3600 OTHER LONG TERM CARE		465,261
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		207,807
40	4000 ANESTHESIOLOGY		245,508
41	4100 RADIOLOGY-DIAGNOSTIC	-13,425	840,723
44	4400 LABORATORY	-15,600	756,847
49	4900 RESPIRATORY THERAPY	-6,000	78,470
50	5000 PHYSICAL THERAPY		361,200
53	5300 ELECTROCARDIOLOGY	-37,265	201,128
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		83,190
56	5600 DRUGS CHARGED TO PATIENTS		747,297
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC	-206,000	33,762
61	6100 EMERGENCY	-398,356	958,777
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC	-27,552	1,750,033
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-850,073	13,150,186
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
100	7950 SARAH D CULBERTSON GARDENS	-60,819	298,603
100.01	7951 MEDICAL ARTS BUILDING		24,055
101	TOTAL	-910,892	13,472,844

COST CENTERS USED IN COST REPORT

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS- BLDG & FIXT	0300	
3.01	NEW CAP REL COSTS- RHCS BLDG/MME	0301	NEW CAP REL COSTS- BLDG & FIXT
3.02	NEW CAP REL COSTS- MED ARTS BLDG/MME	0302	NEW CAP REL COSTS- BLDG & FIXT
4	NEW CAP REL COSTS- MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
8.01	PLANT & HSKPG - RHCS	0801	OPERATION OF PLANT
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY- DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
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 #####
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
100	SARAH D CULBERTSON GARDENS	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	MEDICAL ARTS BUILDING	7951	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		OTHER
	(1)	COST CENTER	LINE NO	SALARY	
	1	2	3	4	5
1 INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	6		32,913
2 PT BLDG PHONE AND UTILITY EXPENSE	B	ADMINISTRATIVE & GENERAL	6		1,068
3		OPERATION OF PLANT	8		3,586
4 BILLABLE MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		31,040
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16 CULBERTSON GARDENS OVERHEAD	D	ADMINISTRATIVE & GENERAL	6		22,668
17		DIETARY	11		40,723
18 PROPERTY INSURANCE	E	OTHER CAPITAL RELATED COSTS	90		30,568
19		SARAH D CULBERTSON GARDENS	100		9,615
20 RHCS OVERHEAD	F	NEW CAP REL COSTS-RHCS BLDG/MME	3.01		28,945
21		NEW CAP REL COSTS-RHCS BLDG/MME	3.01		41,680
22		EMPLOYEE BENEFITS	5		186,502
23		ADMINISTRATIVE & GENERAL	6		82,982
24		PLANT & HSKPG - RHCS	8.01		44,356
25 RENTAL/LEASES	G	NEW CAP REL COSTS-MVBLE EQUIP	4		46,368
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
1 RENTAL/LEASES	G				
2 BILLABLE DRUGS	H	DRUGS CHARGED TO PATIENTS	56		54,353
3 PHYSICIAN RECRUITMENT	I	RURAL HEALTH CLINIC	63.50		115,436
4 HEALTHLINK ADMINISTRATIVE FEES	J	ADMINISTRATIVE & GENERAL	6		26,750
36 TOTAL RECLASSIFICATIONS					799,553

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

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 INTEREST EXPENSE	A	INTEREST EXPENSE	88			32,913	
2 PT BLDG PHONE AND UTILITY EXPENSE	B	PHYSICAL THERAPY	50			4,654	
3							
4 BILLABLE MEDICAL SUPPLIES	C	ADMINISTRATIVE & GENERAL	6			195	
5		DIETARY	11			5	
6		ADULTS & PEDIATRICS	25			4,004	
7		OTHER LONG TERM CARE	36			1,026	
8		OPERATING ROOM	37			19,317	
9		ANESTHESIOLOGY	40			139	
10		RADIOLOGY-DIAGNOSTIC	41			19	
11		LABORATORY	44			27	
12		RESPIRATORY THERAPY	49			220	
13		DRUGS CHARGED TO PATIENTS	56			2,654	
14		CLINIC	60			7	
15		EMERGENCY	61			3,427	
16 CULBERTSON GARDENS OVERHEAD	D	SARAH D CULBERTSON GARDENS	100			63,391	
17							
18 PROPERTY INSURANCE	E	ADMINISTRATIVE & GENERAL	6			40,183	
19							
20 RHCS OVERHEAD	F	RURAL HEALTH CLINIC	63.50			384,465	10
21							9
22							
23							
24							
25 RENTAL/LEASES	G	ADMINISTRATIVE & GENERAL	6			8,228	10
26		OPERATION OF PLANT	8			108	
27		MEDICAL RECORDS & LIBRARY	17			4,633	
28		ADULTS & PEDIATRICS	25			2,279	
29		OTHER LONG TERM CARE	36			3,337	
30		OPERATING ROOM	37			3,059	
31		RADIOLOGY-DIAGNOSTIC	41			1,308	
32		LABORATORY	44			5,545	
33		RESPIRATORY THERAPY	49			4,026	
34		PHYSICAL THERAPY	50			11,435	
35		ELECTROCARDIOLOGY	53			33	
1 RENTAL/LEASES	G	EMERGENCY	61			2,377	
2 BILLABLE DRUGS	H	CLINIC	60			54,353	
3 PHYSICIAN RECRUITMENT	I	ADMINISTRATIVE & GENERAL	6			115,436	
4 HEALTHLINK ADMINISTRATIVE FEES	J	RURAL HEALTH CLINIC	63.50			26,750	
36 TOTAL RECLASSIFICATIONS						799,553	

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

RECLASSIFICATIONS

RECLASS CODE: A
 EXPLANATION : INTEREST EXPENSE

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	32,913
TOTAL RECLASSIFICATIONS FOR CODE A		32,913

DECREASE		
COST CENTER	LINE	AMOUNT
INTEREST EXPENSE	88	32,913
TOTAL RECLASSIFICATIONS FOR CODE A		32,913

RECLASS CODE: B
 EXPLANATION : PT BLDG PHONE AND UTILITY EXPENSE

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	1,068
2.00	OPERATION OF PLANT	3,586
TOTAL RECLASSIFICATIONS FOR CODE B		4,654

DECREASE		
COST CENTER	LINE	AMOUNT
PHYSICAL THERAPY	50	4,654
TOTAL RECLASSIFICATIONS FOR CODE B		4,654

RECLASS CODE: C
 EXPLANATION : BILLABLE MEDICAL SUPPLIES

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	31,040
2.00		0
3.00		0
4.00		0
5.00		0
6.00		0
7.00		0
8.00		0
9.00		0
10.00		0
11.00		0
12.00		0
TOTAL RECLASSIFICATIONS FOR CODE C		31,040

DECREASE		
COST CENTER	LINE	AMOUNT
ADMINISTRATIVE & GENERAL	6	195
DIETARY	11	5
ADULTS & PEDIATRICS	25	4,004
OTHER LONG TERM CARE	36	1,026
OPERATING ROOM	37	19,317
ANESTHESIOLOGY	40	139
RADIOLOGY-DIAGNOSTIC	41	19
LABORATORY	44	27
RESPIRATORY THERAPY	49	220
DRUGS CHARGED TO PATIENTS	56	2,654
CLINIC	60	7
EMERGENCY	61	3,427
TOTAL RECLASSIFICATIONS FOR CODE C		31,040

RECLASS CODE: D
 EXPLANATION : CULBERTSON GARDENS OVERHEAD

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	22,668
2.00	DIETARY	40,723
TOTAL RECLASSIFICATIONS FOR CODE D		63,391

DECREASE		
COST CENTER	LINE	AMOUNT
SARAH D CULBERTSON GARDENS	100	63,391
TOTAL RECLASSIFICATIONS FOR CODE D		63,391

RECLASS CODE: E
 EXPLANATION : PROPERTY INSURANCE

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	OTHER CAPITAL RELATED COSTS	30,568
2.00	SARAH D CULBERTSON GARDENS	9,615
TOTAL RECLASSIFICATIONS FOR CODE E		40,183

DECREASE		
COST CENTER	LINE	AMOUNT
ADMINISTRATIVE & GENERAL	6	40,183
TOTAL RECLASSIFICATIONS FOR CODE E		40,183

RECLASS CODE: F
 EXPLANATION : RHCS OVERHEAD

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	NEW CAP REL COSTS-RHCS BLDG/MM	28,945
2.00	NEW CAP REL COSTS-RHCS BLDG/MM	41,680
3.00	EMPLOYEE BENEFITS	186,502
4.00	ADMINISTRATIVE & GENERAL	82,982
5.00	PLANT & HSKPG - RHCS	44,356
TOTAL RECLASSIFICATIONS FOR CODE F		384,465

DECREASE		
COST CENTER	LINE	AMOUNT
RURAL HEALTH CLINIC	63.50	384,465
TOTAL RECLASSIFICATIONS FOR CODE F		384,465

RECLASS CODE: G
 EXPLANATION : RENTAL/LEASES

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	46,368
2.00		0
3.00		0
4.00		0
5.00		0
6.00		0
7.00		0
8.00		0
9.00		0
10.00		0
11.00		0
12.00		0
TOTAL RECLASSIFICATIONS FOR CODE G		46,368

DECREASE		
COST CENTER	LINE	AMOUNT
ADMINISTRATIVE & GENERAL	6	8,228
OPERATION OF PLANT	8	108
MEDICAL RECORDS & LIBRARY	17	4,633
ADULTS & PEDIATRICS	25	2,279
OTHER LONG TERM CARE	36	3,337
OPERATING ROOM	37	3,059
RADIOLOGY-DIAGNOSTIC	41	1,308
LABORATORY	44	5,545
RESPIRATORY THERAPY	49	4,026
PHYSICAL THERAPY	50	11,435
ELECTROCARDIOLOGY	53	33
EMERGENCY	61	2,377
TOTAL RECLASSIFICATIONS FOR CODE G		46,368

RECLASSIFICATIONS

RECLASS CODE: H
 EXPLANATION : BILLABLE DRUGS

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	54,353	CLINIC	60	54,353	54,353
TOTAL RECLASSIFICATIONS FOR CODE H			54,353				54,353

RECLASS CODE: I
 EXPLANATION : PHYSICIAN RECRUITMENT

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	RURAL HEALTH CLINIC	63.50	115,436	ADMINISTRATIVE & GENERAL	6	115,436	115,436
TOTAL RECLASSIFICATIONS FOR CODE I			115,436				115,436

RECLASS CODE: J
 EXPLANATION : HEALTHLINK ADMINISTRATIVE FEES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	26,750	RURAL HEALTH CLINIC	63.50	26,750	26,750
TOTAL RECLASSIFICATIONS FOR CODE J			26,750				26,750

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3					
1	LAND	289,461						289,461	
2	LAND IMPROVEMENTS	755,494						755,494	
3	BUILDINGS & FIXTURE	6,318,278	104,893		104,893			6,423,171	
4	BUILDING IMPROVEMEN	41,678	116,861		116,861			158,539	
5	FIXED EQUIPMENT	193,423					37,377	156,046	
6	MOVABLE EQUIPMENT	4,445,447	440,524		440,524	379,728		4,506,243	
7	SUBTOTAL	12,043,781	662,278		662,278	417,105		12,288,954	
8	RECONCILING ITEMS								
9	TOTAL	12,043,781	662,278		662,278	417,105		12,288,954	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	GROSS ASSETS	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
	1	2	3	4	5	6	7	8
* NEW CAP REL COSTS-BL	6,737,756		6,737,756	.599231	18,317			18,317
3 01 NEW CAP REL COSTS-RH	314,780		314,780	.027995	856			856
3 02 NEW CAP REL COSTS-ME	75,330		75,330	.006700	205			205
4 NEW CAP REL COSTS-MV	4,116,133		4,116,133	.366074	11,190			11,190
5 TOTAL	11,243,999		11,243,999	1.000000	30,568			30,568

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST		
	9	10	11	12	13	14	15	
* NEW CAP REL COSTS-BL	130,415			18,317			148,732	
3 01 NEW CAP REL COSTS-RH	41,680	28,945		856			71,481	
3 02 NEW CAP REL COSTS-ME	14,680			205			14,885	
4 NEW CAP REL COSTS-MV	227,181	46,368		11,190			284,739	
5 TOTAL	413,956	75,313		30,568			519,837	

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4
 DESCRIPTION SUMMARY OF OLD AND NEW CAPITAL

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL							TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST		
	9	10	11	12	13	14	15	
* NEW CAP REL COSTS-BL	130,415						130,415	
3 01 NEW CAP REL COSTS-RH	41,680						41,680	
3 02 NEW CAP REL COSTS-ME	14,680						14,680	
4 NEW CAP REL COSTS-MV	227,181						227,181	
5 TOTAL	372,276						372,276	

* All lines numbers except line 5 are to be consistent with Workshseet 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

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5 INVESTMENT INCOME-OTHER	B	-35,948	ADMINISTRATIVE & GENERAL	6	
6 TRADE QUANTITY AND TIME DISCOUNTS	B	-1,597	ADMINISTRATIVE & GENERAL	6	
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-676,646			
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 EMPLOYEE AND OTHERS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-7,623	MEDICAL RECORDS & LIBRARY	17	
21 NURSG SCHOOL(TUITN, FEES, BOOKS, ETC.)	A	-395	DIETARY	11	
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37 MEALS ON WHEELS	B	-73,214	DIETARY	11	
38 OPC RENT	B	-8,075	ADMINISTRATIVE & GENERAL	6	
39 RHC PROMOTION COSTS	A	-16,158	RURAL HEALTH CLINIC	63.50	
40 INTEREST INCOME	B	-60,819	SARAH D CULBERTSON GARDEN	100	
41 RHC MISCELLANEOUS INCOME	B	-11,394	RURAL HEALTH CLINIC	63.50	
42 LOBBYING PORTION OF DUES	A	-5,679	ADMINISTRATIVE & GENERAL	6	
43 MARKETING WAGES	A	-34,314	ADMINISTRATIVE & GENERAL	6	
44 MARKETING BENEFIT EXPENSE	A	-9,902	EMPLOYEE BENEFITS	5	
45 MARKETING OTHER EXPENSE	A	-22,169	ADMINISTRATIVE & GENERAL	6	
46 PHYSICIAN RECRUITMENT	A	-42,784	ADMINISTRATIVE & GENERAL	6	
47 NONALLOWABLE LEGAL FEES	A	-11,859	ADMINISTRATIVE & GENERAL	6	
48 CLINIC PRE-OPERATING EXPENSES	A	-420	ADMINISTRATIVE & GENERAL	6	
49 LIFELINE	A	37,729	ADMINISTRATIVE & GENERAL	6	
49.01 HEALTHLINK ADMINISTRATIVE FEES	A	70,375	ADMINISTRATIVE & GENERAL	6	
50 TOTAL (SUM OF LINES 1 THRU 49)		-910,892			

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	CONTRACTED LABOR	156,369	156,369	
2						
3						
4						
5		TOTALS		156,369	156,369	

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) NAME	PERCENTAGE OF OWNERSHIP	HOME OFFICE TYPE OF BUSINESS	
1	2	3	4	5	6	
1	E	DAVID SNIFF, CEO	100.00	MIDWEST CONSULTANTS	0.00	MANAGEMENT COMPANY
2			0.00		0.00	
3			0.00		0.00	
4			0.00		0.00	
5			0.00		0.00	

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

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	41	RADIOLOGY	1,425	1,425				
2	44	PATHOLOGIST/AGGREGATE	15,600	15,600				
3	60	ONCOLOGIST	96,000	96,000				
4	60	GI	110,000	110,000				
5	53	CARDIOLOGIST	37,265	37,265				
6	61	ER/AGGREGATE	940,850	398,356	542,494			
7	49	RESPIRATORY	6,000	6,000				
8	41	NUCLEAR MEDICINE	12,000	12,000				
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,219,140	676,646	542,494				

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	41	RADIOLOGY						1,425
2	44	PATHOLOGIST/AGGREGATE						15,600
3	60	ONCOLOGIST						96,000
4	60	GI						110,000
5	53	CARDIOLOGIST						37,265
6	61	ER/AGGREGATE						398,356
7	49	RESPIRATORY						6,000
8	41	NUCLEAR MEDICINE						12,000
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101		TOTAL						676,646

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	8
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	120
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)	6
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9	TOTAL HOURS WORKED	52.42			
10	AHSEA (SEE INSTRUCTIONS)	61.59			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	30.80	30.80		
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)	3,229
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)	3,229
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)	3,229

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)	61.60
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	7,392
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	7,392

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)	21
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	21
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 (LN 8 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)	21
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)	

OCCUPATIONAL THERAPY

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)					
49 CALCULATION OF LIMIT 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)					
52 DETERMINATION OF OVERTIME ALLOWANCE 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 I, LINE 23)	7,392
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	21
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)	7,413
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	2,000
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)	2,000
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)	2,000
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)	

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

PROVIDER NO:
14-1333

IN LIEU OF FORM CMS-2552-96(12/1999)
PERIOD: PREPARED 7/16/2008
FROM 3/1/2007 WORKSHEET A-8-4
TO 2/29/2008 PARTS I - VII

OCCUPATIONAL THERAPY

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

COST ALLOCATION STATISTICS

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
3.01	NEW CAP REL COSTS-RHCS BLDG/MME	4	SQUARE	FEET	ENTERED
3.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	7	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM	COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
8.01	PLANT & HSKPG - RHCS	4	SQUARE	FEET	ENTERED
10	HOUSEKEEPING	3	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	MEALS	SERVED	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED

COST CENTER DESCRPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-RHCS BL	NEW CAP REL C OSTS-MED ART	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL
	0	3	3.01	3.02	4	5	5a.00
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &	148,732	148,732					
003 01 NEW CAP REL COSTS-RHCS BL	71,481		71,481				
003 02 NEW CAP REL COSTS-MED ART	14,885			14,885			
004 NEW CAP REL COSTS-MVBLE E	284,739				284,739		
005 EMPLOYEE BENEFITS	1,676,547					1,676,547	
006 ADMINISTRATIVE & GENERAL	1,871,163	31,282			59,887	251,695	2,214,027
008 OPERATION OF PLANT	408,634	10,102			19,339	54,330	492,405
008 01 PLANT & HSKPG - RHCS	44,356						44,356
010 HOUSEKEEPING	261,158	5,039			9,647	64,801	340,645
011 DIETARY	453,188	9,600			18,378	76,286	557,452
012 CAFETERIA							
014 NURSING ADMINISTRATION	149,454					39,215	188,669
017 MEDICAL RECORDS & LIBRARY	316,516	9,833			18,824	87,225	432,398
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	719,330	18,144			34,736	187,313	959,523
036 OTHER LONG TERM CARE	465,261	18,413			35,251	119,758	638,683
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	207,807	4,656			8,914	36,553	257,930
040 ANESTHESIOLOGY	245,508					64,648	310,156
041 RADIOLOGY-DIAGNOSTIC	840,723	7,911			15,144	85,478	949,256
044 LABORATORY	756,847	2,933			5,616	84,415	849,811
049 RESPIRATORY THERAPY	78,470	1,555			2,976		83,001
050 PHYSICAL THERAPY	361,200	7,566			14,486	92,420	475,672
053 ELECTROCARDIOLOGY	201,128					20,753	221,881
055 MEDICAL SUPPLIES CHARGED	83,190	7,344			14,060	12,668	117,262
056 DRUGS CHARGED TO PATIENTS	747,297	1,891			3,620		752,808
OUTPAT SERVICE COST CNTRS							
060 CLINIC	33,762	8,976			17,185	8,940	68,863
061 EMERGENCY	958,777	3,487			6,676	103,880	1,072,820
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	1,750,033		71,481			246,567	2,068,081
063 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	13,150,186	148,732	71,481		284,739	1,636,945	13,095,699
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
100 SARAH D CULBERTSON GARDEN	298,603					39,602	338,205
101 01 MEDICAL ARTS BUILDING	24,055			14,885			38,940
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	13,472,844	148,732	71,481	14,885	284,739	1,676,547	13,472,844

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	PLANT & HSKPG - RHCS	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
		6	8	8.01	10	11	12	14
003	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
003	01 NEW CAP REL COSTS-RHCS BL							
004	02 NEW CAP REL COSTS-MED ART							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL	2,214,027						
008	OPERATION OF PLANT	96,830	589,235					
008	01 PLANT & HSKPG - RHCS	8,723		53,079				
010	HOUSEKEEPING	66,987	27,660		435,292			
011	DIETARY	109,622	52,693		40,844	760,611		
012	CAFETERIA					185,179	185,179	
014	NURSING ADMINISTRATION	37,101					3,802	229,572
017	MEDICAL RECORDS & LIBRARY	85,030	53,971		41,834		22,106	
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	188,688	99,593		77,197	77,601	35,401	79,734
036	OTHER LONG TERM CARE	125,596	101,069		78,342	312,449	32,265	72,665
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	50,721	25,558		19,811		5,371	12,093
040	ANESTHESIOLOGY	60,992					3,741	8,416
041	RADIOLOGY-DIAGNOSTIC	186,669	43,421		33,657		14,241	
044	LABORATORY	167,114	16,102		12,481		14,081	
049	RESPIRATORY THERAPY	16,322	8,534		6,615			
050	PHYSICAL THERAPY	93,540	41,532		32,193		11,948	
053	ELECTROCARDIOLOGY	43,632					3,782	8,502
055	MEDICAL SUPPLIES CHARGED	23,059	40,311		31,246		3,802	
056	DRUGS CHARGED TO PATIENTS	148,038	10,380		8,045			
	OUTPAT SERVICE COST CNTRS							
060	CLINIC	13,542	49,271		38,191		2,052	4,614
061	EMERGENCY	210,968	19,140		14,836		19,351	43,548
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063	50 RURAL HEALTH CLINIC	406,689		53,079				
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	2,139,863	589,235	53,079	435,292	575,229	171,943	229,572
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
100	SARAH D CULBERTSON GARDEN	66,507				185,382	13,236	
101	01 MEDICAL ARTS BUILDING	7,657						
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	2,214,027	589,235	53,079	435,292	760,611	185,179	229,572

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	25	26	27
003 GENERAL SERVICE COST CNTR				
003 01 NEW CAP REL COSTS-BLDG &				
003 02 NEW CAP REL COSTS-RHCS BL				
004 NEW CAP REL COSTS-MVBLE E				
005 EMPLOYEE BENEFITS				
006 ADMINISTRATIVE & GENERAL				
008 OPERATION OF PLANT				
008 01 PLANT & HSKPG - RHCS				
010 HOUSEKEEPING				
011 DIETARY				
012 CAFETERIA				
014 NURSING ADMINISTRATION				
017 MEDICAL RECORDS & LIBRARY	635,339			
025 INPAT ROUTINE SRVC CNTRS				
036 ADULTS & PEDIATRICS	188,382	1,706,119		1,706,119
	4,129	1,365,198		1,365,198
037 ANCILLARY SRVC COST CNTRS				
040 OPERATING ROOM		371,484		371,484
041 ANESTHESIOLOGY		383,305		383,305
041 RADIOLOGY-DIAGNOSTIC	70,601	1,297,845		1,297,845
044 LABORATORY	42,577	1,102,166		1,102,166
049 RESPIRATORY THERAPY	1,083	115,555		115,555
050 PHYSICAL THERAPY	3,655	658,540		658,540
053 ELECTROCARDIOLOGY	18,547	296,344		296,344
055 MEDICAL SUPPLIES CHARGED		215,680		215,680
056 DRUGS CHARGED TO PATIENTS		919,271		919,271
060 OUTPAT SERVICE COST CNTRS				
061 CLINIC	75,001	251,534		251,534
062 EMERGENCY	105,664	1,486,327		1,486,327
062 OBSERVATION BEDS (NON-DIS				
063 OTHER OUTPATIENT SERVICE				
063 50 RURAL HEALTH CLINIC	125,700	2,653,549		2,653,549
063 SPEC PURPOSE COST CENTERS				
095 SUBTOTALS	635,339	12,822,917		12,822,917
095 NONREIMBURS COST CENTERS				
100 GIFT, FLOWER, COFFEE SHOP				
100 SARAH D CULBERTSON GARDEN		603,330		603,330
100 01 MEDICAL ARTS BUILDING		46,597		46,597
101 CROSS FOOT ADJUSTMENT				
102 NEGATIVE COST CENTER				
103 TOTAL	635,339	13,472,844		13,472,844

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-RHCS BL	NEW CAP REL C OSTS-MED ART	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS
	0	3	3.01	3.02	4	4a	5
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG &							
003 02 NEW CAP REL COSTS-RHCS BL							
004 NEW CAP REL COSTS-MED ART							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		31,282			59,887	91,169	
008 OPERATION OF PLANT		10,102			19,339	29,441	
008 01 PLANT & HSKPG - RHCS							
010 HOUSEKEEPING		5,039			9,647	14,686	
011 DIETARY		9,600			18,378	27,978	
012 CAFETERIA							
014 NURSING ADMINISTRATION							
017 MEDICAL RECORDS & LIBRARY		9,833			18,824	28,657	
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		18,144			34,736	52,880	
036 OTHER LONG TERM CARE		18,413			35,251	53,664	
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		4,656			8,914	13,570	
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		7,911			15,144	23,055	
044 LABORATORY		2,933			5,616	8,549	
049 RESPIRATORY THERAPY		1,555			2,976	4,531	
050 PHYSICAL THERAPY		7,566			14,486	22,052	
053 ELECTROCARDIOLOGY							
055 MEDICAL SUPPLIES CHARGED		7,344			14,060	21,404	
056 DRUGS CHARGED TO PATIENTS		1,891			3,620	5,511	
OUTPAT SERVICE COST CNTRS							
060 CLINIC		8,976			17,185	26,161	
061 EMERGENCY		3,487			6,676	10,163	
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC			71,481			71,481	
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		148,732	71,481		284,739	504,952	
NONREIMBURS COST CENTERS							
100 GIFT, FLOWER, COFFEE SHOP							
100 SARAH D CULBERTSON GARDEN	100,787					100,787	
101 01 MEDICAL ARTS BUILDING				14,885		14,885	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	100,787	148,732	71,481	14,885	284,739	620,624	

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	PLANT & HSKPG - RHCS	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
	6	8	8.01	10	11	12	14
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG &							
003 02 NEW CAP REL COSTS-RHCS BL							
004 NEW CAP REL COSTS-MED ART							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL	91,169						
008 OPERATION OF PLANT	3,987	33,428					
008 01 PLANT & HSKPG - RHCS		359	359				
010 HOUSEKEEPING	2,759	1,569		19,014			
011 DIETARY	4,514	2,989		1,784	37,265		
012 CAFETERIA					9,073	9,073	
014 NURSING ADMINISTRATION	1,528					186	1,714
017 MEDICAL RECORDS & LIBRARY	3,502	3,062		1,827		1,083	
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	7,770	5,650		3,372	3,802	1,736	596
036 OTHER LONG TERM CARE	5,172	5,735		3,424	15,307	1,581	543
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	2,089	1,450		865		263	90
040 ANESTHESIOLOGY	2,512					183	63
041 RADIOLOGY-DIAGNOSTIC	7,687	2,463		1,470		698	
044 LABORATORY	6,882	913		545		690	
049 RESPIRATORY THERAPY	672	484		289			
050 PHYSICAL THERAPY	3,852	2,356		1,406		585	
053 ELECTROCARDIOLOGY	1,797					185	63
055 MEDICAL SUPPLIES CHARGED	950	2,287		1,365		186	
056 DRUGS CHARGED TO PATIENTS	6,096	589		351			
OUTPAT SERVICE COST CNTRS							
060 CLINIC	558	2,795		1,668		101	34
061 EMERGENCY	8,688	1,086		648		948	325
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
50 RURAL HEALTH CLINIC	16,741		359				
SPECIAL PURPOSE COST CENTERS							
095 SUBTOTALS	88,115	33,428	359	19,014	28,182	8,425	1,714
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
100 SARAH D CULBERTSON GARDEN	2,739				9,083	648	
01 MEDICAL ARTS BUILDING	315						
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	91,169	33,428	359	19,014	37,265	9,073	1,714

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	25	26	27
003 GENERAL SERVICE COST CNTR				
003 01 NEW CAP REL COSTS-BLDG &				
003 02 NEW CAP REL COSTS-RHCS BL				
004 NEW CAP REL COSTS-MVBLE E				
005 EMPLOYEE BENEFITS				
006 ADMINISTRATIVE & GENERAL				
008 OPERATION OF PLANT				
008 01 PLANT & HSKPG - RHCS				
010 HOUSEKEEPING				
011 DIETARY				
012 CAFETERIA				
014 NURSING ADMINISTRATION				
017 MEDICAL RECORDS & LIBRARY	38,131			
025 INPAT ROUTINE SRVC CNTRS				
036 ADULTS & PEDIATRICS	11,307	87,113		87,113
	248	85,674		85,674
037 ANCILLARY SRVC COST CNTRS				
040 OPERATING ROOM		18,327		18,327
041 ANESTHESIOLOGY		2,758		2,758
044 RADIOLOGY-DIAGNOSTIC	4,237	39,610		39,610
049 LABORATORY	2,555	20,134		20,134
050 RESPIRATORY THERAPY	65	6,041		6,041
053 PHYSICAL THERAPY	219	30,470		30,470
055 ELECTROCARDIOLOGY	1,113	3,158		3,158
056 MEDICAL SUPPLIES CHARGED		26,192		26,192
		12,547		12,547
060 DRUGS CHARGED TO PATIENTS				
061 OUTPAT SERVICE COST CNTRS				
062 CLINIC	4,501	35,818		35,818
063 EMERGENCY	6,342	28,200		28,200
063 50 OBSERVATION BEDS (NON-DIS				
063 50 OTHER OUTPATIENT SERVICE				
063 50 RURAL HEALTH CLINIC	7,544	96,125		96,125
095 SPEC PURPOSE COST CENTERS				
095 SUBTOTALS	38,131	492,167		492,167
096 NONREIMBURS COST CENTERS				
100 GIFT, FLOWER, COFFEE SHOP				
100 01 SARAH D CULBERTSON GARDEN		113,257		113,257
101 MEDICAL ARTS BUILDING		15,200		15,200
102 CROSS FOOT ADJUSTMENTS				
103 NEGATIVE COST CENTER				
TOTAL	38,131	620,624		620,624

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRPTION	NEW CAP REL C	EMPLOYEE BENE	RECONCIL- IATION			
	OSTS-BLDG &	OSTS-RHCS BL	OSTS-MED ART	OSTS-MVBLE E	FITS	
	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARIES)	
	3	3.01	3.02	4	5	6a.00
003 GENERAL SERVICE COST						
003 01 NEW CAP REL COSTS- BLD	57,496					
003 02 NEW CAP REL COSTS- RHC		11,800				
004 NEW CAP REL COSTS-MED			9,400			
005 NEW CAP REL COSTS-MVB				57,496		
006 EMPLOYEE BENEFITS					5,809,602	
008 ADMINISTRATIVE & GENE	12,093			12,093	872,184	-2,214,027
008 01 OPERATION OF PLANT	3,905			3,905	188,266	
008 01 PLANT & HSKPG - RHCS						
010 HOUSEKEEPING	1,948			1,948	224,550	
011 DIETARY	3,711			3,711	264,347	
012 CAFETERIA						
014 NURSING ADMINISTRATION					135,887	
017 MEDICAL RECORDS & LIB	3,801			3,801	302,255	
025 INPAT ROUTINE SRVC CN						
036 ADULTS & PEDIATRICS	7,014			7,014	649,080	
036 OTHER LONG TERM CARE	7,118			7,118	414,989	
037 ANCILLARY SRVC COST C						
040 OPERATING ROOM	1,800			1,800	126,664	
041 ANESTHESIOLOGY					224,021	
044 RADIOLOGY-DIAGNOSTIC	3,058			3,058	296,200	
049 LABORATORY	1,134			1,134	292,515	
050 RESPIRATORY THERAPY	601			601		
053 PHYSICAL THERAPY	2,925			2,925	320,254	
055 ELECTROCARDIOLOGY					71,912	
056 MEDICAL SUPPLIES CHAR	2,839			2,839	43,896	
060 DRUGS CHARGED TO PATI	731			731		
060 OUTPAT SERVICE COST C						
061 CLINIC	3,470			3,470	30,978	
062 EMERGENCY	1,348			1,348	359,966	
063 OBSERVATION BEDS (NON						
063 50 OTHER OUTPATIENT SERV						
063 50 RURAL HEALTH CLINIC		11,800			854,409	
095 SPEC PURPOSE COST CEN						
095 SUBTOTALS	57,496	11,800		57,496	5,672,373	-2,214,027
096 NONREIMBURS COST CENT						
100 GIFT, FLOWER, COFFEE						
100 01 SARAH D CULBERTSON GA			9,400		137,229	
101 MEDICAL ARTS BUILDING						
102 CROSS FOOT ADJUSTMENT						
103 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	148,732	71,481	14,885	284,739	1,676,547	
104 (WRKSH B, PART I)						
104 UNIT COST MULTIPLIER	2.586823		1.583511		.288582	
105 (WRKSH B, PT I)						
105 COST TO BE ALLOCATED		6.057712		4.952327		
106 (WRKSH B, PART II)						
106 UNIT COST MULTIPLIER						
107 (WRKSH B, PT II)						
107 COST TO BE ALLOCATED						
108 (WRKSH B, PART III)						
108 UNIT COST MULTIPLIER						
108 (WRKSH B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	ADMINISTRATIVE OPERATION OF PLANT		PLANT & HSKPG - RHCS		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
	(COST)	(FEET)	(FEET)	(FEET)	(FEET)	(MEALS SERVED)	(MEALS SERVED)	(DIRECT NRSNG HRS)
	6	8	8.01		10	11	12	14
003 GENERAL SERVICE COST								
003 01 NEW CAP REL COSTS-BLD								
003 02 NEW CAP REL COSTS-RHC								
004 NEW CAP REL COSTS-MED								
005 NEW CAP REL COSTS-MVB								
006 EMPLOYEE BENEFITS								
008 ADMINISTRATIVE & GENE	11,258,817							
008 01 OPERATION OF PLANT	492,405	41,498						
008 01 PLANT & HSKPG - RHCS	44,356		11,800					
010 HOUSEKEEPING	340,645	1,948			39,550			
011 DIETARY	557,452	3,711			3,711	59,829		
012 CAFETERIA						14,566	9,206	
014 NURSING ADMINISTRATION	188,669						189	90,347
017 MEDICAL RECORDS & LIB	432,398	3,801			3,801		1,099	
025 INPAT ROUTINE SRVC CN								
025 ADULTS & PEDIATRICS	959,523	7,014			7,014	6,104	1,760	31,379
036 OTHER LONG TERM CARE	638,683	7,118			7,118	24,577	1,604	28,597
037 ANCILLARY SRVC COST C								
040 OPERATING ROOM	257,930	1,800			1,800		267	4,759
040 ANESTHESIOLOGY	310,156						186	3,312
041 RADIOLOGY-DIAGNOSTIC	949,256	3,058			3,058		708	
044 LABORATORY	849,811	1,134			1,134		700	
049 RESPIRATORY THERAPY	83,001	601			601			
050 PHYSICAL THERAPY	475,672	2,925			2,925		594	
053 ELECTROCARDIOLOGY	221,881						188	3,346
055 MEDICAL SUPPLIES CHAR	117,262	2,839			2,839		189	
056 DRUGS CHARGED TO PATI	752,808	731			731			
060 OUTPAT SERVICE COST C								
060 CLINIC	68,863	3,470			3,470		102	1,816
061 EMERGENCY	1,072,820	1,348			1,348		962	17,138
062 OBSERVATION BEDS (NON								
063 OTHER OUTPATIENT SERV								
063 50 RURAL HEALTH CLINIC	2,068,081		11,800					
063 SPC PURPOSE COST CEN								
095 SUBTOTALS	10,881,672	41,498	11,800		39,550	45,247	8,548	90,347
096 NONREIMBURS COST CENT								
100 GIFT, FLOWER, COFFEE								
100 01 SARAH D CULBERTSON GA	338,205					14,582	658	
100 01 MEDICAL ARTS BUILDING	38,940							
101 CROSS FOOT ADJUSTMENT								
102 NEGATIVE COST CENTER								
103 COST TO BE ALLOCATED	2,214,027	589,235	53,079		435,292	760,611	185,179	229,572
(WRKSHT B, PART I)								
104 UNIT COST MULTIPLIER		14.199118			11.006119		20.115034	
(WRKSHT B, PT I)								
105 COST TO BE ALLOCATED	.196648		4.498220			12.713082		2.541003
(WRKSHT B, PART II)								
106 UNIT COST MULTIPLIER								
(WRKSHT B, PT II)								
107 COST TO BE ALLOCATED	91,169	33,428	359		19,014	37,265	9,073	1,714
(WRKSHT B, PART III)								
108 UNIT COST MULTIPLIER		.805533			.480759		.985553	
(WRKSHT B, PT III)	.008098		.030424			.622858		.018971

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION		MEDICAL RECORDS & LIBRARY
		(TIME SPENT)
		17
	GENERAL SERVICE COST	
003	NEW CAP REL COSTS-BLD	
003 01	NEW CAP REL COSTS-RHC	
003 02	NEW CAP REL COSTS-MED	
004	NEW CAP REL COSTS-MVB	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENE	
008	OPERATION OF PLANT	
008 01	PLANT & HSKPG - RHCS	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATION	
017	MEDICAL RECORDS & LIB	9,386
	INPAT ROUTINE SRVC CN	
025	ADULTS & PEDIATRICS	2,783
036	OTHER LONG TERM CARE	61
	ANCILLARY SRVC COST C	
037	OPERATING ROOM	
040	ANESTHESIOLOGY	
041	RADIOLOGY-DIAGNOSTIC	1,043
044	LABORATORY	629
049	RESPIRATORY THERAPY	16
050	PHYSICAL THERAPY	54
053	ELECTROCARDIOLOGY	274
055	MEDICAL SUPPLIES CHAR	
056	DRUGS CHARGED TO PATI	
	OUTPAT SERVICE COST C	
060	CLINIC	1,108
061	EMERGENCY	1,561
062	OBSERVATION BEDS (NON	
063	OTHER OUTPATIENT SERV	
063 50	RURAL HEALTH CLINIC	1,857
	SPEC PURPOSE COST CEN	
095	SUBTOTALS	9,386
	NONREIMBURS COST CENT	
096	GIFT, FLOWER, COFFEE	
100	SARAH D CULBERTSON GA	
100 01	MEDICAL ARTS BUILDING	
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	COST TO BE ALLOCATED	635,339
	(PER WRKSHT B, PART	
104	UNIT COST MULTIPLIER	
	(WRKSHT B, PT I)	67.690070
105	COST TO BE ALLOCATED	
	(PER WRKSHT B, PART	
106	UNIT COST MULTIPLIER	
	(WRKSHT B, PT II)	
107	COST TO BE ALLOCATED	38,131
	(PER WRKSHT B, PART	
108	UNIT COST MULTIPLIER	
	(WRKSHT B, PT III)	4.062540

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO:
I 14-1333
II PERIOD:
I FROM 3/ 1/2007
I TO 2/29/2008
II PREPARED 7/16/2008
I WORKSHEET C
I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	1,706,119		1,706,119		
36	OTHER LONG TERM CARE	1,365,198		1,365,198		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	371,484		371,484		
40	ANESTHESIOLOGY	383,305		383,305		
41	RADIOLOGY-DIAGNOSTIC	1,297,845		1,297,845		
44	LABORATORY	1,102,166		1,102,166		
49	RESPIRATORY THERAPY	115,555		115,555		
50	PHYSICAL THERAPY	658,540		658,540		
53	ELECTROCARDIOLOGY	296,344		296,344		
55	MEDICAL SUPPLIES CHARGED	215,680		215,680		
56	DRUGS CHARGED TO PATIENTS	919,271		919,271		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	251,534		251,534		
61	EMERGENCY	1,486,327		1,486,327		
62	OBSERVATION BEDS (NON-DIS	332,918		332,918		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	2,653,549		2,653,549		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	13,155,835		13,155,835		
102	LESS OBSERVATION BEDS	332,918		332,918		
103	TOTAL	12,822,917		12,822,917		

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,083,058		1,083,058			
36	OTHER LONG TERM CARE	905,355		905,355			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	77,783	1,291,852	1,369,635	.271228	.271228	
40	ANESTHESIOLOGY	41,850	497,719	539,569	.710391	.710391	
41	RADIOLOGY-DIAGNOSTIC	169,325	5,342,963	5,512,288	.235446	.235446	
44	LABORATORY	257,068	2,837,329	3,094,397	.356181	.356181	
49	RESPIRATORY THERAPY	41,026	237,360	278,386	.415089	.415089	
50	PHYSICAL THERAPY	165,255	1,145,059	1,310,314	.502582	.502582	
53	ELECTROCARDIOLOGY	115,435	1,337,807	1,453,242	.203919	.203919	
55	MEDICAL SUPPLIES CHARGED	255,303	136,835	392,138	.550010	.550010	
56	DRUGS CHARGED TO PATIENTS	1,020,895	1,811,884	2,832,779	.324512	.324512	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	3,505	550,137	553,642	.454326	.454326	
61	EMERGENCY	38,151	2,636,388	2,674,539	.555732	.555732	
62	OBSERVATION BEDS (NON-DIS	883	293,217	294,100	1.131989	1.131989	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		1,273,335	1,273,335	2.083936	2.083936	
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	4,174,892	19,391,885	23,566,777			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,174,892	19,391,885	23,566,777			

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	1,706,119		1,706,119		
36	OTHER LONG TERM CARE	1,365,198		1,365,198		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	371,484		371,484		
40	ANESTHESIOLOGY	383,305		383,305		
41	RADIOLOGY-DIAGNOSTIC	1,297,845		1,297,845		
44	LABORATORY	1,102,166		1,102,166		
49	RESPIRATORY THERAPY	115,555		115,555		
50	PHYSICAL THERAPY	658,540		658,540		
53	ELECTROCARDIOLOGY	296,344		296,344		
55	MEDICAL SUPPLIES CHARGED	215,680		215,680		
56	DRUGS CHARGED TO PATIENTS	919,271		919,271		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	251,534		251,534		
61	EMERGENCY	1,486,327		1,486,327		
62	OBSERVATION BEDS (NON-DIS	332,918		332,918		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	2,653,549		2,653,549		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	13,155,835		13,155,835		
102	LESS OBSERVATION BEDS	332,918		332,918		
103	TOTAL	12,822,917		12,822,917		

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,083,058		1,083,058			
36	OTHER LONG TERM CARE	905,355		905,355			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	77,783	1,291,852	1,369,635	.271228	.271228	
40	ANESTHESIOLOGY	41,850	497,719	539,569	.710391	.710391	
41	RADIOLOGY-DIAGNOSTIC	169,325	5,342,963	5,512,288	.235446	.235446	
44	LABORATORY	257,068	2,837,329	3,094,397	.356181	.356181	
49	RESPIRATORY THERAPY	41,026	237,360	278,386	.415089	.415089	
50	PHYSICAL THERAPY	165,255	1,145,059	1,310,314	.502582	.502582	
53	ELECTROCARDIOLOGY	115,435	1,337,807	1,453,242	.203919	.203919	
55	MEDICAL SUPPLIES CHARGED	255,303	136,835	392,138	.550010	.550010	
56	DRUGS CHARGED TO PATIENTS	1,020,895	1,811,884	2,832,779	.324512	.324512	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	3,505	550,137	553,642	.454326	.454326	
61	EMERGENCY	38,151	2,636,388	2,674,539	.555732	.555732	
62	OBSERVATION BEDS (NON-DIS	883	293,217	294,100	1.131989	1.131989	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		1,273,335	1,273,335	2.083936	2.083936	
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	4,174,892	19,391,885	23,566,777			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,174,892	19,391,885	23,566,777			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	371,484	18,327	353,157			371,484
40	ANESTHESIOLOGY	383,305	2,758	380,547			383,305
41	RADIOLOGY-DIAGNOSTIC	1,297,845	39,610	1,258,235			1,297,845
44	LABORATORY	1,102,166	20,134	1,082,032			1,102,166
49	RESPIRATORY THERAPY	115,555	6,041	109,514			115,555
50	PHYSICAL THERAPY	658,540	30,470	628,070			658,540
53	ELECTROCARDIOLOGY	296,344	3,158	293,186			296,344
55	MEDICAL SUPPLIES CHARGED	215,680	26,192	189,488			215,680
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	919,271	12,547	906,724			919,271
60	CLINIC	251,534	35,818	215,716			251,534
61	EMERGENCY	1,486,327	28,200	1,458,127			1,486,327
62	OBSERVATION BEDS (NON-DIS	332,918		332,918			332,918
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	2,653,549	96,125	2,557,424			2,653,549
101	SUBTOTAL	10,084,518	319,380	9,765,138			10,084,518
102	LESS OBSERVATION BEDS	332,918		332,918			332,918
103	TOTAL	9,751,600	319,380	9,432,220			9,751,600

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	1,369,635	.271228	.271228
40	ANESTHESIOLOGY	539,569	.710391	.710391
41	RADIOLOGY-DIAGNOSTIC	5,512,288	.235446	.235446
44	LABORATORY	3,094,397	.356181	.356181
49	RESPIRATORY THERAPY	278,386	.415089	.415089
50	PHYSICAL THERAPY	1,310,314	.502582	.502582
53	ELECTROCARDIOLOGY	1,453,242	.203919	.203919
55	MEDICAL SUPPLIES CHARGED	392,138	.550010	.550010
56	DRUGS CHARGED TO PATIENTS	2,832,779	.324512	.324512
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	553,642	.454326	.454326
61	EMERGENCY	2,674,539	.555732	.555732
62	OBSERVATION BEDS (NON-DIS	294,100	1.131989	1.131989
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	1,273,335	2.083936	2.083936
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	21,578,364		
102	LESS OBSERVATION BEDS	294,100		
103	TOTAL	21,284,264		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	371,484	18,327	353,157			371,484
40	ANESTHESIOLOGY	383,305	2,758	380,547			383,305
41	RADIOLOGY-DIAGNOSTIC	1,297,845	39,610	1,258,235			1,297,845
44	LABORATORY	1,102,166	20,134	1,082,032			1,102,166
49	RESPIRATORY THERAPY	115,555	6,041	109,514			115,555
50	PHYSICAL THERAPY	658,540	30,470	628,070			658,540
53	ELECTROCARDIOLOGY	296,344	3,158	293,186			296,344
55	MEDICAL SUPPLIES CHARGED	215,680	26,192	189,488			215,680
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	919,271	12,547	906,724			919,271
60	CLINIC	251,534	35,818	215,716			251,534
61	EMERGENCY	1,486,327	28,200	1,458,127			1,486,327
62	OBSERVATION BEDS (NON-DIS OTHER OUTPATIENT SERVICE	332,918		332,918			332,918
63	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	2,653,549	96,125	2,557,424			2,653,549
101	SUBTOTAL	10,084,518	319,380	9,765,138			10,084,518
102	LESS OBSERVATION BEDS	332,918		332,918			332,918
103	TOTAL	9,751,600	319,380	9,432,220			9,751,600

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	1,369,635	.271228	.271228
40	ANESTHESIOLOGY	539,569	.710391	.710391
41	RADIOLOGY-DIAGNOSTIC	5,512,288	.235446	.235446
44	LABORATORY	3,094,397	.356181	.356181
49	RESPIRATORY THERAPY	278,386	.415089	.415089
50	PHYSICAL THERAPY	1,310,314	.502582	.502582
53	ELECTROCARDIOLOGY	1,453,242	.203919	.203919
55	MEDICAL SUPPLIES CHARGED	392,138	.550010	.550010
56	DRUGS CHARGED TO PATIENTS	2,832,779	.324512	.324512
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	553,642	.454326	.454326
61	EMERGENCY	2,674,539	.555732	.555732
62	OBSERVATION BEDS (NON-DIS	294,100	1.131989	1.131989
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	1,273,335	2.083936	2.083936
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	21,578,364		
102	LESS OBSERVATION BEDS	294,100		
103	TOTAL	21,284,264		

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge	Cost/Charge	Cost/Charge	Outpatient	Outpatient
	Ratio (C, Pt I, col. 9)	Ratio (C, Pt I, col. 9)	Ratio (C, Pt II, col. 9)	Ambulatory Surgical Ctr	Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.271228		.271228		
40 ANESTHESIOLOGY	.710391		.710391		
41 RADIOLOGY-DIAGNOSTIC	.235446		.235446		
44 LABORATORY	.356181		.356181		
49 RESPIRATORY THERAPY	.415089		.415089		
50 PHYSICAL THERAPY	.502582		.502582		
53 ELECTROCARDIOLOGY	.203919		.203919		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.550010		.550010		
56 DRUGS CHARGED TO PATIENTS	.324512		.324512		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	.454326		.454326		
61 EMERGENCY	.555732		.555732		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.131989		1.131989		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
104 PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		646,197			
40 ANESTHESIOLOGY		205,779			
41 RADIOLOGY-DIAGNOSTIC		2,320,684			
44 LABORATORY		1,566,615			
49 RESPIRATORY THERAPY		18,674			
50 PHYSICAL THERAPY		468,050			
53 ELECTROCARDIOLOGY		641,470			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		117,954			
56 DRUGS CHARGED TO PATIENTS		1,372,279			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		74,585			
61 EMERGENCY		1,000,479			
62 OBSERVATION BEDS (NON-DISTINCT PART)		216,126			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
101 SUBTOTAL		8,648,892			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES		8,648,892			

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

TITLE XVIII, PART B

HOSPITAL

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

Cost Center Description 9 10 11

(A)	Cost Center Description	9	10	11
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM		175,267	
40	ANESTHESIOLOGY		146,184	
41	RADIOLOGY-DIAGNOSTIC		546,396	
44	LABORATORY		557,998	
49	RESPIRATORY THERAPY		7,751	
50	PHYSICAL THERAPY		235,234	
53	ELECTROCARDIOLOGY		130,808	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		64,876	
56	DRUGS CHARGED TO PATIENTS		445,321	
	OUTPAT SERVICE COST CNTRS			
60	CLINIC		33,886	
61	EMERGENCY		555,998	
62	OBSERVATION BEDS (NON-DISTINCT PART)		244,652	
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
101	SUBTOTAL	3,144,371		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-			
104	PROGRAM ONLY CHARGES			
	NET CHARGES	3,144,371		

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

TITLE XVIII, PART B HOSPITAL
 PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.324512
2	PROGRAM VACCINE CHARGES		9,204
3	PROGRAM COSTS		2,987

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)	2,033
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,394
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,394
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	523
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)	71
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	45
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)	721
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	523
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)	71
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	105.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	105.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1,706,119
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	4,725
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	513,088
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,193,031

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,122,297
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,122,297
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.063026
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	805.09
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	1,193,031

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					855.83
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					617,053
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					617,053

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT					
	HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49	TOTAL PROGRAM INPATIENT COSTS					357,738

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)					447,599
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)					60,764
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS					508,363
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD					
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD					
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS					

TITLE XVIII PART A HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY 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 389
 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 855.83
 85 OBSERVATION BED COST 332,918

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				

WKST A LINE NO.	TITLE XVIII, PART A COST CENTER DESCRIPTION	HOSPITAL RATIO COST TO CHARGES 1	OTHER	
			INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		592,830	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.271228	25,213	6,838
40	ANESTHESIOLOGY	.710391	10,809	7,679
41	RADIOLOGY-DIAGNOSTIC	.235446	118,913	27,998
44	LABORATORY	.356181	163,954	58,397
49	RESPIRATORY THERAPY	.415089	20,523	8,519
50	PHYSICAL THERAPY	.502582	21,385	10,748
53	ELECTROCARDIOLOGY	.203919	52,794	10,766
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.550010	136,776	75,228
56	DRUGS CHARGED TO PATIENTS	.324512	467,055	151,565
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.454326		
61	EMERGENCY	.555732		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.131989		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		1,017,422	357,738
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,017,422	

WKST A LINE NO.	TITLE XVIII, PART A COST CENTER DESCRIPTION	SWING BED SNF RATIO COST TO CHARGES 1	OTHER INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.271228		
40	ANESTHESIOLOGY	.710391		
41	RADIOLOGY-DIAGNOSTIC	.235446	3,767	887
44	LABORATORY	.356181	24,972	8,895
49	RESPIRATORY THERAPY	.415089	13,655	5,668
50	PHYSICAL THERAPY	.502582	133,930	67,311
53	ELECTROCARDIOLOGY	.203919	2,184	445
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.550010	76,000	41,801
56	DRUGS CHARGED TO PATIENTS	.324512	119,461	38,767
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.454326		
61	EMERGENCY	.555732		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.131989		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		373,969	163,774
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		373,969	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,147,358
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	3,147,358

COMPUTATION OF LESSER OF COST OR CHARGES

6	REASONABLE CHARGES	
7	ANCILLARY SERVICE CHARGES	
8	INTERNS AND RESIDENTS SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES	
10	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
11	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	3,178,832
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	CAH DEDUCTIBLES	46,412
18.01	CAH ACTUAL BILLED COINSURANCE	1,421,234
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	1,711,186
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	1,711,186
24	PRIMARY PAYER PAYMENTS	1,897
25	SUBTOTAL	1,709,289
26	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	259,992
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	259,992
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	223,757
28	SUBTOTAL	1,969,281
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	1,969,281
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	1,993,696
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-24,415
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT- PART A		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		813,680		1,993,696
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	6/11/2007	8,500		
ADJUSTMENTS TO PROVIDER .02	9/4/2007	4,800		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04	12/5/2007	1,500		
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	3/7/2008	103,400		
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		-88,600		NONE
4 TOTAL INTERIM PAYMENTS		725,080		1,993,696
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT- PART A		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		552,170		NONE
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	9/10/2007	15,000		
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				
ADJUSTMENTS TO PROGRAM .99				
4 TOTAL INTERIM PAYMENTS		567,170		NONE
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
TENTATIVE TO PROGRAM .99				
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		NONE		NONE
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	513,447	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	165,412	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS		594
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	678,859	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	678,859	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	678,859	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	14,366	
14	80% OF PART B COSTS		
15	SUBTOTAL	664,493	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	664,493	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	567,170	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	97,323	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	974,791
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	974,791
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST FOR CAH (SEE INSTRUCTIONS)	984,539

COMPUTATION OF LESSER OF COST OR CHARGES

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

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	984,539
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	140,544
21	EXCESS REASONABLE COST	
22	SUBTOTAL	843,995
23	COINSURANCE	1,736
24	SUBTOTAL	842,259
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	31,219
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	31,219
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	31,219
26	SUBTOTAL	873,478
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	873,478
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	725,080
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	148,398
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	3,094,960			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	2,791,457			
5	OTHER RECEIVABLES	733,897			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	316,643			
8	PREPAID EXPENSES	49,883			
9	OTHER CURRENT ASSETS	673,191			
10	DUE FROM OTHER FUNDS	4,740,150			
11	TOTAL CURRENT ASSETS	12,400,181			
FIXED ASSETS					
12	LAND	289,461			
12.01	LAND IMPROVEMENTS	565,735			
13	LESS ACCUMULATED DEPRECIATION	-228,858			
14	BUILDINGS	4,158,327			
14.01	LESS ACCUMULATED DEPRECIATION	-3,132,749			
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	7,275,432			
18.01	LESS ACCUMULATED DEPRECIATION	-4,768,904			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	4,158,444			
OTHER ASSETS					
22	INVESTMENTS	242,850			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	62,932			
26	TOTAL OTHER ASSETS	305,782			
27	TOTAL ASSETS	16,864,407			

BALANCE SHEET

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	564,229			
29 SALARIES, WAGES & FEES PAYABLE	743,654			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	200,000			
32 DEFERRED INCOME	253,367			
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES				
36 TOTAL CURRENT LIABILITIES	1,761,250			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	1,509,468			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	4,738,636			
42 TOTAL LONG-TERM LIABILITIES	6,248,104			
43 TOTAL LIABILITIES	8,009,354			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	8,855,053			
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	8,855,053			
52 TOTAL LIABILITIES AND FUND BALANCES	16,864,407			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND	
	1	2
1 FUND BALANCE AT BEGINNING		7,060,519
2 OF PERIOD		
3 NET INCOME (LOSS)		1,794,534
4 TOTAL		8,855,053
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		8,855,053
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		8,855,053
PERIOD PER BALANCE SHEET		

SPECIFIC PURPOSE FUND

3 4

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

PLANT FUND

7 8

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
1 00 GENERAL INPATIENT ROUTINE CARE SERVICES			
4 00 HOSPITAL	1,122,297		1,122,297
5 00 SWING BED - SNF	254,861		254,861
8 00 SWING BED - NF			
9 00 OTHER LONG TERM CARE	905,355		905,355
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS	2,282,513		2,282,513
16 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
17 00 TOTAL INPATIENT ROUTINE CARE SERVICE	2,282,513		2,282,513
17 00 ANCILLARY SERVICES	2,204,762		2,204,762
18 00 OUTPATIENT SERVICES		19,145,764	19,145,764
18 50 RURAL HEALTH CLINIC		2,895,418	2,895,418
24 00 CULBERTSON GARDENS		407,551	407,551
24 01			
25 00 TOTAL PATIENT REVENUES	4,487,275	22,448,733	26,936,008

PART II - OPERATING EXPENSES

26 00 OPERATING EXPENSES		14,383,736	
ADD (SPECIFY)			
27 00 BAD DEBT EXPENSE	1,309,182		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		1,309,182	
DEDUCT (SPECIFY)			
34 00			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		15,692,918	

STATEMENT OF REVENUES AND EXPENSES

DESCRIPTION		
1	TOTAL PATIENT REVENUES	26,936,008
2	LESS: ALLOWANCES AND DISCOUNTS ON	10,492,632
3	NET PATIENT REVENUES	16,443,376
4	LESS: TOTAL OPERATING EXPENSES	15,692,918
5	NET INCOME FROM SERVICE TO PATIENT	750,458
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	47,878
7	INCOME FROM INVESTMENTS	121,079
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	1,597
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	7,623
19	TUTION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	16,918
23	GOVERNMENTAL APPROPRIATIONS	733,885
24	OPC RENT	8,075
24.01	GRANT INCOME	27,143
24.02	OTHER	4,123
24.03	MEALS ON WHEELS	73,214
24.04	GAIN ON DISPOSAL	2,541
25	TOTAL OTHER INCOME	1,044,076
26	TOTAL	1,794,534
	OTHER EXPENSES	
27		
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	1,794,534

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN	152,526		152,526	
3 PHYSICIAN ASSISTANT	160,138		160,138	
4 NURSE PRACTITIONER	76,193		76,193	
5 VISITING NURSE				
6 OTHER NURSE	283,366		283,366	
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 LABORATORY TECHNICIAN				
10 OTHER FACILITY HEALTH CARE STAFF COSTS				
10 SUBTOTAL (SUM OF LINES 1-9)	672,223		672,223	
11 COSTS UNDER AGREEMENT				
12 PHYSICIAN SERVICES UNDER AGREEMENT		543,332	543,332	
13 PHYSICIAN SUPERVISION UNDER AGREEMENT		29,115	29,115	
14 OTHER COSTS UNDER AGREEMENT				
14 SUBTOTAL (SUM OF LINES 11-13)		572,447	572,447	
15 OTHER HEALTH CARE COSTS				
16 MEDICAL SUPPLIES		74,867	74,867	
17 TRANSPORTATION (HEALTH CARE STAFF)				
18 DEPRECIATION-MEDICAL EQUIPMENT				
19 PROFESSIONAL LIABILITY INSURANCE				
20 OTHER HEALTH CARE COSTS		87,625	87,625	
21 ALLOWABLE GME COSTS				
22 SUBTOTAL (SUM OF LINES 15-20)		162,492	162,492	
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	672,223	734,939	1,407,162	
23 COSTS OTHER THAN RHC/FQHC SERVICES				
24 PHARMACY				
25 DENTAL				
26 OPTOMETRY				
27 ALL OTHER NONREIMBURSABLE COSTS				
28 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
29 FACILITY OVERHEAD				
30 FACILITY COSTS		116,676	116,676	-114,981
31 ADMINISTRATIVE COSTS	182,186	367,340	549,526	-180,798
32 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	182,186	484,016	666,202	-295,779
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	854,409	1,218,955	2,073,364	-295,779
	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7	
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN	152,526		152,526	
3 PHYSICIAN ASSISTANT	160,138		160,138	
4 NURSE PRACTITIONER	76,193		76,193	
5 VISITING NURSE				
6 OTHER NURSE	283,366		283,366	
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 LABORATORY TECHNICIAN				
10 OTHER FACILITY HEALTH CARE STAFF COSTS				
10 SUBTOTAL (SUM OF LINES 1-9)	672,223		672,223	
11 COSTS UNDER AGREEMENT				
12 PHYSICIAN SERVICES UNDER AGREEMENT	543,332		543,332	
13 PHYSICIAN SUPERVISION UNDER AGREEMENT	29,115		29,115	
14 OTHER COSTS UNDER AGREEMENT				
14 SUBTOTAL (SUM OF LINES 11-13)	572,447		572,447	
15 OTHER HEALTH CARE COSTS				
16 MEDICAL SUPPLIES	74,867		74,867	
17 TRANSPORTATION (HEALTH CARE STAFF)				
18 DEPRECIATION-MEDICAL EQUIPMENT				
19 PROFESSIONAL LIABILITY INSURANCE				
20 OTHER HEALTH CARE COSTS	87,625		87,625	
21 ALLOWABLE GME COSTS				
22 SUBTOTAL (SUM OF LINES 15-20)	162,492		162,492	
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,407,162		1,407,162	
23 COSTS OTHER THAN RHC/FQHC SERVICES				
24 PHARMACY				
25 DENTAL				
26 OPTOMETRY				
27 ALL OTHER NONREIMBURSABLE COSTS				
28 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
29 FACILITY OVERHEAD				
30 FACILITY COSTS	1,695		1,695	
31 ADMINISTRATIVE COSTS	368,728	-27,552	341,176	
32 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	370,423	-27,552	342,871	
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,777,585	-27,552	1,750,033	

ALLOCATION OF OVERHEAD
 TO RHC/FQHC SERVICES

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD (1) 3	MINIMUM VISITS 4
1 POSITIONS				
2 PHYSICIANS	.75	2,437	4,200	3,150
3 PHYSICIAN ASSISTANTS	1.64	4,512	2,100	3,444
4 NURSE PRACTITIONERS	.77	3,171	2,100	1,617
5 SUBTOTAL (SUM OF LINES 1-3)	3.16	10,120		8,211
6 VISITING NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	3.16	10,120		
10 PHYSICIAN SERVICES UNDER AGREEMENTS		7,176		
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
11 TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	1,407,162			
12 TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
13 COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	1,407,162			
14 RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000			
15 TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	342,871			
16 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	903,516			
17 TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	1,246,387			
18 ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
19 SUBTRACT LINE 17 FROM LINE 16	1,246,387			
20 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	1,246,387			
TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	2,653,549			
	GREATER OF COL. 2 OR COL. 4 5			
1 POSITIONS				
2 PHYSICIANS				
3 PHYSICIAN ASSISTANTS				
4 NURSE PRACTITIONERS				
5 SUBTOTAL (SUM OF LINES 1-3)	10,120			
6 VISITING NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	10,120			
PHYSICIAN SERVICES UNDER AGREEMENTS		7,176		

(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.

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	2,653,549
	(FROM WORKSHEET M-2, LINE 20)	
2	COST OF VACCINES AND THEIR ADMINISTRATION	15,754
	(FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	2,637,795
	(LINE 1 MINUS LINE 2)	
4	TOTAL VISITS	10,120
	(FROM WORKSHEET M-2, COLUMN 5, LINE 8)	
5	PHYSICIANS VISITS UNDER AGREEMENT	7,176
	(FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	17,296
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	152.51

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
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	152.51
10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	5,489
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	837,127
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)*	837,127
16.01	PRIMARY PAYER AMOUNT	
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	27,870
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	809,257
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	647,406
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	15,753
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	663,159
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	1,905
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)	665,064
25	INTERIM PAYMENTS	431,896
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	233,168
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.

TITLE XVIII RHC 1

	PNEUMOCOCCAL 1	INFLUENZA 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	672, 223	672, 223
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	. 000149	. 002526
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	100	1, 698
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	572	5, 984
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	672	7, 682
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	1, 407, 162	1, 407, 162
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	1, 246, 387	1, 246, 387
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	. 000478	. 005459
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	596	6, 804
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	1, 268	14, 486
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	22	374
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	57. 64	38. 73
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	22	374
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	1, 268	14, 485
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		15, 754
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		15, 753

RHC 1

DESCRIPTION

P A R T B
 MM/DD/YYYY AMOUNT

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			431,896
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			NONE
	ADJUSTMENTS TO PROVIDER	.01		
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	ADJUSTMENTS TO PROGRAM	.55		
	ADJUSTMENTS TO PROGRAM	.99		
	SUBTOTAL			NONE
4	TOTAL INTERIM PAYMENTS			431,896
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	TENTATIVE TO PROGRAM	.99		
	SUBTOTAL			NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01	
		SETTLEMENT TO PROGRAM	.02	
7	TOTAL MEDICARE PROGRAM LIABILITY			

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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