

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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	14-1320	I	FROM 1/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/27/2010 TIME 9:04

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
PARIS COMMUNITY HOSPITAL 14-1320
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2009 AND ENDING 12/31/2009 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.

ECR ENCRYPTION INFORMATION
DATE: 5/27/2010 TIME 9:04

SJEKuzmFKsFwP1R5ACmVr6HVbt1a0
jRj170ihg1GnkovQ6LCKbLP38dQm9.
DFAr0y8wAa0s4a6e

PI ENCRYPTION INFORMATION
DATE: 5/27/2010 TIME 9:04

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jOzn90Hkws7Q0xuj1KntuGIAIa1NDbx
ox:B4ATAJz01pT1q

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	0
1	HOSPITAL	0	250,106	127,233		0
3	SWING BED - SNF	0	70,142	0		0
9	RHC	0	0	121,362		0
9 .01	RHC II	0	0	10,475		0
9 .02	RHC III	0	0	3,018		0
100	TOTAL	0	320,248	262,088		0

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

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

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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	14-1320	I	FROM 1/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
			I	TO 12/31/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
			I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/27/2010 TIME 9:14

PART I - CERTIFICATION

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 PARIS COMMUNITY HOSPITAL 14-1320
 FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2009 AND ENDING 12/31/2009 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	250,106		127,233	0
3	SWING BED - SNF	0	70,142		0	0
9	RHC	0	0		121,362	0
9 .01	RHC II	0	0		10,475	0
9 .02	RHC III	0	0		3,018	0
100	TOTAL	0	320,248		262,088	0

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 721 EAST COURT STREET P.O. BOX:
 1.01 CITY: PARIS STATE: IL ZIP CODE: 61944- COUNTY: EDGAR

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V 4	XVIII 5	XIX 6
02.00 HOSPITAL	PARIS COMMUNITY HOSPITAL	14-1320		6/30/2002	N	O	N
04.00 SWING BED - SNF	PARIS COMMUNITY HOSPITAL	14-2320		6/30/2002	N	O	N
14.00 HOSPITAL-BASED RHC	FMC	14-3987		9/24/1994	N	O	N
14.01 HOSPITAL-BASED RHC 2	HATCH	14-3989		1/ 1/1995	N	O	N
14.02 HOSPITAL-BASED RHC 3	FMC	14-3431		2/16/1997	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2009 TO: 12/31/2009
 18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

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

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N

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

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 N Y 14999

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 §105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO. N

21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

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

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

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

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /

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

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

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?
 25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N
 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(b)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)
 25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.
 SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 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 6/30/2002

28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02

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

	1	2	3	4
28.02	0	0.0000	0.0000	
28.02	0.00	0		

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

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

	%	Y/N
28.03 STAFFING	1.00%	Y
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 ELIBLIE 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 ELIBLIE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

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

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

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

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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

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

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

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
 46 IF YOU ARE PARTICIPATING IN THE NHCQM 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: 0
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0

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

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

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

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

MULTICAMPUS

- 61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA?
ENTER "Y" FOR YES AND "N" FOR NO.
- IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3,
CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

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

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / O/P VISITS / TITLE XVIII 4	NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	25	9,125	46,968.00		1,350		188
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)					606		
3 ADULTS & PED-SB SNF							3,826
4 ADULTS & PED-SB NF							4,014
5 TOTAL ADULTS AND PEDS	25	9,125	46,968.00		1,956		4,014
12 TOTAL	25	9,125	46,968.00		1,956		4,014
13 RPCH VISITS							
24 RURAL HEALTH CLINIC					9,540		
24 01 RURAL HEALTH CLINIC 2					355		
24 02 RURAL HEALTH CLINIC 3					119		
25 TOTAL	25						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX OBSERVATION BEDS ADMITTED 5.01	I/P DAYS / NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	INTERNS & RES. TOTAL 7	FTES -- LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			2,010				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			606				
4 ADULTS & PED-SB NF			3,826				
5 TOTAL ADULTS AND PEDS			6,442				
12 TOTAL			6,442				
13 RPCH VISITS							
24 RURAL HEALTH CLINIC			45,249				
24 01 RURAL HEALTH CLINIC 2			2,237				
24 02 RURAL HEALTH CLINIC 3			999				
25 TOTAL			114				
26 OBSERVATION BED DAYS					114		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

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					439	68	625
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS					439	68	625
12 TOTAL		168.45			439	68	625
13 RPCH VISITS							
24 RURAL HEALTH CLINIC		51.97					
24 01 RURAL HEALTH CLINIC 2		2.98					
24 02 RURAL HEALTH CLINIC 3		1.19					
25 TOTAL		224.59					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

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

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		
11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.)		N

FACILITY HOURS OF OPERATIONS (1)

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

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVIII TITLE XIX

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

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

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

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

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		
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	1200	1330	1930			800	1200	800	1200		

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVIII TITLE XIX

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

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

RHC 3

CLINIC ADDRESS AND IDENTIFICATION

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

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	DATE
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		
	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		
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			830	1200			830	1200	1330	1700				

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVIII TITLE XIX

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

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

DESCRIPTION

UNCOMPENSATED CARE INFORMATION		
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
UNCOMPENSATED CARE REVENUES		
17	REVENUE FROM UNCOMPENSATED CARE	1,287,998
17.01	GROSS MEDICAID REVENUES	5,616,557
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	6,904,555
UNCOMPENSATED CARE COST		
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.513301
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	5,616,557

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
I 14-1320 I FROM 1/ 1/2009 I WORKSHEET S-10
I I TO 12/31/2009 I
I I I

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	2,882,984
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	2,882,984

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 14-1320
I

I PERIOD:
I FROM 1/ 1/2009 I
I TO 12/31/2009 I
I PREPARED 5/27/2010
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		986,547	986,547	232,336	1,218,883
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		824,436	824,436	126,055	950,491
5	0500 EMPLOYEE BENEFITS	104,659	3,650,212	3,754,871	-260,337	3,494,534
6.01	0660 OTHER ADMINISTRATIVE AND GENERAL	1,010,408	2,606,840	3,617,248	-137,863	3,479,385
6.02	0661 ADMITTING	465,733	155,346	621,079	-742	620,337
8	0800 OPERATION OF PLANT	333,490	542,975	876,465	-2,725	873,740
9	0900 LAUNDRY & LINEN SERVICE		104,024	104,024		104,024
10	1000 HOUSEKEEPING	192,384	50,069	242,453		242,453
11	1100 DIETARY	346,018	181,838	527,856	-279,344	248,512
12	1200 CAFETERIA				279,344	279,344
14	1400 NURSING ADMINISTRATION	522,737	16,298	539,035	-260	538,775
16	1600 PHARMACY	147,246	728,236	875,482	-713,032	162,450
17	1700 MEDICAL RECORDS & LIBRARY	311,882	45,767	357,649		357,649
18	1800 SOCIAL SERVICE		49,950	49,950		49,950
25	2500 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	1,380,054	57,281	1,437,335	-10,502	1,426,833
37	3700 ANCILLARY SRVC COST CNTRS OPERATING ROOM	515,893	399,434	915,327	-279,193	636,134
40	4000 ANESTHESIOLOGY	451,934	39,508	491,442	118,335	609,777
41	4100 RADIOLOGY-DIAGNOSTIC	1,224,923	988,956	2,213,879	74,749	2,288,628
44	4400 LABORATORY	625,013	667,219	1,292,232	-464	1,291,768
49	4900 RESPIRATORY THERAPY	160,360	28,055	188,415	-28,603	159,812
50	5000 PHYSICAL THERAPY	637,237	128,311	765,548		765,548
53	5300 ELECTROCARDIOLOGY		58,850	58,850	47,425	106,275
54	5400 ELECTROENCEPHALOGRAPHY		101,112	101,112		101,112
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS				331,534	331,534
56	5600 DRUGS CHARGED TO PATIENTS				778,889	778,889
59	3020 CARDIAC REHAB OUTPAT SERVICE COST CNTRS	84,552	44,504	129,056	-20,616	108,440
60	6000 CLINIC	236,785	81,667	318,452		318,452
61	6100 EMERGENCY	835,890	1,309,887	2,145,777		2,145,777
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	3,073,763	627,592	3,701,355	-23,288	3,678,067
63.51	6311 RURAL HEALTH CLINIC 2	188,948	86,845	275,793	-29,342	246,451
63.52	6312 RURAL HEALTH CLINIC 3	101,528	44,478	146,006	-17,158	128,848
88	8800 SPEC PURPOSE COST CENTERS INTEREST EXPENSE		183,430	183,430	-183,430	
95	SUBTOTALS	12,951,437	14,789,667	27,741,104	1,768	27,742,872
98	9800 NONREIMBURS COST CENTERS PHYSICIANS' PRIVATE OFFICES	858,977	167,786	1,026,763	-1,768	1,024,995
101	TOTAL	13,810,414	14,957,453	28,767,867	-0-	28,767,867

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 14-1320
II PERIOD:
I FROM 1/ 1/2009
I TO 12/31/2009I PREPARED 5/27/2010
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-218,179	1,000,704
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		950,491
5	0500 EMPLOYEE BENEFITS		3,494,534
6.01	0660 OTHER ADMINISTRATIVE AND GENERAL	-91,105	3,388,280
6.02	0661 ADMITTING		620,337
8	0800 OPERATION OF PLANT		873,740
9	0900 LAUNDRY & LINEN SERVICE		104,024
10	1000 HOUSEKEEPING		242,453
11	1100 DIETARY		248,512
12	1200 CAFETERIA	-87,239	192,105
14	1400 NURSING ADMINISTRATION		538,775
16	1600 PHARMACY		162,450
17	1700 MEDICAL RECORDS & LIBRARY	-1,355	356,294
18	1800 SOCIAL SERVICE		49,950
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		1,426,833
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		636,134
40	4000 ANESTHESIOLOGY	-586,614	23,163
41	4100 RADIOLOGY-DIAGNOSTIC	-779,800	1,508,828
44	4400 LABORATORY		1,291,768
49	4900 RESPIRATORY THERAPY		159,812
50	5000 PHYSICAL THERAPY		765,548
53	5300 ELECTROCARDIOLOGY	-57,791	48,484
54	5400 ELECTROENCEPHALOGRAPHY	-100,124	988
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,510	330,024
56	5600 DRUGS CHARGED TO PATIENTS	-40,961	737,928
59	3020 CARDIAC REHAB	-20,444	87,996
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC	-54,990	263,462
61	6100 EMERGENCY	-1,006,855	1,138,922
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC	-156,796	3,521,271
63.51	6311 RURAL HEALTH CLINIC 2	-4,157	242,294
63.52	6312 RURAL HEALTH CLINIC 3	-1,264	127,584
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
95	SUBTOTALS	-3,209,184	24,533,688
	NONREIMBURS COST CENTERS		
98	9800 PHYSICIANS' PRIVATE OFFICES	-12,104	1,012,891
101	TOTAL	-3,221,288	25,546,579

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I NOT A CMS WORKSHEET
 I I TO 12/31/2009 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6.01	OTHER ADMINISTRATIVE AND GENERAL	0660	OTHER ADMINISTRATIVE AND GENERAL
6.02	ADMITTING	0661	OTHER ADMINISTRATIVE AND GENERAL
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	CARDIAC REHAB	3020	ACUPUNCTURE
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
63.51	RURAL HEALTH CLINIC 2	6311	RURAL HEALTH CLINIC #####
63.52	RURAL HEALTH CLINIC 3	6312	RURAL HEALTH CLINIC #####
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
98	PHYSICIANS' PRIVATE OFFICES	9800	
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:
141320

PERIOD:
FROM 1/ 1/2009
TO 12/31/2009

PREPARED 5/27/2010
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		LINE		SALARY	OTHER
	(1)	COST CENTER	NO			
1 RENTAL EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4			126,055
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14 CAFETERIA	B	CAFETERIA	12		183,114	96,230
15 EKG	C	ELECTROCARDIOLOGY	53		26,809	
16						
17 PROPERTY INSURANCE	D	NEW CAP REL COSTS-BLDG & FIXT	3			48,906
18 OXYGEN/PATIENT SUPPLIES	E	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			82,735
19						
20 DRUGS	F	DRUGS CHARGED TO PATIENTS	56			778,889
21						
22 TELEPHONE	H	OTHER ADMINISTRATIVE AND GENERAL	6.01			38,207
23						
24						
25						
26 STRESS TEST	I	ELECTROCARDIOLOGY	53		13,507	7,109
27 MED SUPPLIES	J	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			248,799
28 INTEREST EXPENSE	K	NEW CAP REL COSTS-BLDG & FIXT	3			183,430
29 ANESTHESIA BENEFITS	L	ANESTHESIOLOGY	40			119,731
30 RADIOLOGY BENEFITS	M	RADIOLOGY-DIAGNOSTIC	41			137,923
31 WOUND CARE BENEFITS	N	RADIOLOGY-DIAGNOSTIC	41			2,683
36 TOTAL RECLASSIFICATIONS					223,430	1,870,697

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

RECLASSIFICATIONS

PROVIDER NO:
141320

PERIOD:
FROM 1/ 1/2009
TO 12/31/2009

PREPARED 5/27/2010
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 RENTAL EXPENSE	A	OTHER ADMINISTRATIVE AND GENERAL	6.01			52,557	10
2		ADMITTING	6.02			742	
3		OPERATION OF PLANT	8			2,725	
4		ADULTS & PEDIATRICS	25			2,034	
5		OPERATING ROOM	37			30,394	
6		ANESTHESIOLOGY	40			1,396	
7		LABORATORY	44			464	
8		RESPIRATORY THERAPY	49			2,134	
9		RURAL HEALTH CLINIC	63.50			6,915	
10		RURAL HEALTH CLINIC 2	63.51			18,801	
11		RURAL HEALTH CLINIC 3	63.52			7,108	
12		PHYSICIANS' PRIVATE OFFICES	98			525	
13		NURSING ADMINISTRATION	14			260	
14 CAFETERIA	B	DIETARY	11		183,114	96,230	
15 EKG	C	ADULTS & PEDIATRICS	25		8,468		
16		RESPIRATORY THERAPY	49		18,341		
17 PROPERTY INSURANCE	D	OTHER ADMINISTRATIVE AND GENERAL	6.01			48,906	11
18 OXYGEN/PATIENT SUPPLIES	E	OTHER ADMINISTRATIVE AND GENERAL	6.01			74,607	
19		RESPIRATORY THERAPY	49			8,128	
20 DRUGS	F	PHARMACY	16			713,032	
21		RADIOLOGY-DIAGNOSTIC	41			65,857	
22 TELEPHONE	H	RURAL HEALTH CLINIC	63.50			16,373	
23		RURAL HEALTH CLINIC 2	63.51			10,541	
24		RURAL HEALTH CLINIC 3	63.52			10,050	
25		PHYSICIANS' PRIVATE OFFICES	98			1,243	
26 STRESS TEST	I	CARDIAC REHAB	59		13,507	7,109	
27 MED SUPPLIES	J	OPERATING ROOM	37			248,799	
28 INTEREST EXPENSE	K	INTEREST EXPENSE	88			183,430	11
29 ANESTHESIA BENEFITS	L	EMPLOYEE BENEFITS	5			119,731	
30 RADIOLOGY BENEFITS	M	EMPLOYEE BENEFITS	5			137,923	
31 WOUND CARE BENEFITS	N	EMPLOYEE BENEFITS	5			2,683	
36 TOTAL RECLASSIFICATIONS					223,430	1,870,697	

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

RECLASSIFICATIONS

PROVIDER NO:
141320

PERIOD:
FROM 1/ 1/2009
TO 12/31/2009

PREPARED 5/27/2010
WORKSHEET A-6
NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : RENTAL EXPENSE

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	126,055
2.00			0
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
8.00			0
10.00			0
11.00			0
12.00			0
13.00			0
14.00			0
TOTAL RECLASSIFICATIONS FOR CODE A			126,055

DECREASE			
COST CENTER	LINE	AMOUNT	
OTHER ADMINISTRATIVE AND GENER	6.01	52,557	
ADMITTING	6.02	742	
OPERATION OF PLANT	8	2,725	
ADULTS & PEDIATRICS	25	2,034	
OPERATING ROOM	37	30,394	
ANESTHESIOLOGY	40	1,396	
LABORATORY	44	464	
RESPIRATORY THERAPY	49	2,134	
RURAL HEALTH CLINIC	63.50	6,915	
RURAL HEALTH CLINIC 2	63.51	18,801	
RURAL HEALTH CLINIC 3	63.52	7,108	
PHYSICIANS' PRIVATE OFFICES	98	525	
NURSING ADMINISTRATION	14	260	
		126,055	

RECLASS CODE: B
EXPLANATION : CAFETERIA

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	279,344
TOTAL RECLASSIFICATIONS FOR CODE B			279,344

DECREASE			
COST CENTER	LINE	AMOUNT	
DIETARY	11	279,344	
		279,344	

RECLASS CODE: C
EXPLANATION : EKG

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	26,809
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE C			26,809

DECREASE			
COST CENTER	LINE	AMOUNT	
ADULTS & PEDIATRICS	25	8,468	
RESPIRATORY THERAPY	49	18,341	
		26,809	

RECLASS CODE: D
EXPLANATION : PROPERTY INSURANCE

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	48,906
TOTAL RECLASSIFICATIONS FOR CODE D			48,906

DECREASE			
COST CENTER	LINE	AMOUNT	
OTHER ADMINISTRATIVE AND GENER	6.01	48,906	
		48,906	

RECLASS CODE: E
EXPLANATION : OXYGEN/PATIENT SUPPLIES

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	82,735
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE E			82,735

DECREASE			
COST CENTER	LINE	AMOUNT	
OTHER ADMINISTRATIVE AND GENER	6.01	74,607	
RESPIRATORY THERAPY	49	8,128	
		82,735	

RECLASS CODE: F
EXPLANATION : DRUGS

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	778,889
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE F			778,889

DECREASE			
COST CENTER	LINE	AMOUNT	
PHARMACY	16	713,032	
RADIOLOGY-DIAGNOSTIC	41	65,857	
		778,889	

RECLASS CODE: H
EXPLANATION : TELEPHONE

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	OTHER ADMINISTRATIVE AND GENER	6.01	38,207
2.00			0
3.00			0
4.00			0
TOTAL RECLASSIFICATIONS FOR CODE H			38,207

DECREASE			
COST CENTER	LINE	AMOUNT	
RURAL HEALTH CLINIC	63.50	16,373	
RURAL HEALTH CLINIC 2	63.51	10,541	
RURAL HEALTH CLINIC 3	63.52	10,050	
PHYSICIANS' PRIVATE OFFICES	98	1,243	
		38,207	

RECLASS CODE: I
EXPLANATION : STRESS TEST

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	20,616
TOTAL RECLASSIFICATIONS FOR CODE I			20,616

DECREASE			
COST CENTER	LINE	AMOUNT	
CARDIAC REHAB	59	20,616	
		20,616	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141320	FROM 1/ 1/2009	5/27/2010
	TO 12/31/2009	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: J
EXPLANATION : MED SUPPLIES

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	248,799
TOTAL RECLASSIFICATIONS FOR CODE J			248,799

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
OPERATING ROOM	37	248,799

RECLASS CODE: K
EXPLANATION : INTEREST EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	183,430
TOTAL RECLASSIFICATIONS FOR CODE K			183,430

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
INTEREST EXPENSE	88	183,430

RECLASS CODE: L
EXPLANATION : ANESTHESIA BENEFITS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ANESTHESIOLOGY	40	119,731
TOTAL RECLASSIFICATIONS FOR CODE L			119,731

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
EMPLOYEE BENEFITS	5	119,731

RECLASS CODE: M
EXPLANATION : RADIOLOGY BENEFITS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	RADIOLOGY-DIAGNOSTIC	41	137,923
TOTAL RECLASSIFICATIONS FOR CODE M			137,923

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
EMPLOYEE BENEFITS	5	137,923

RECLASS CODE: N
EXPLANATION : WOUND CARE BENEFITS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	RADIOLOGY-DIAGNOSTIC	41	2,683
TOTAL RECLASSIFICATIONS FOR CODE N			2,683

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
EMPLOYEE BENEFITS	5	2,683

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	34,112						34,112	
2 LAND IMPROVEMENTS	1,780,886	5,153			5,153		1,786,039	
3 BUILDINGS & FIXTURE	19,112,833	956,462			956,462		20,069,295	
4 BUILDING IMPROVEMEN								
5 FIXED EQUIPMENT	8,068,527	529,885			529,885		8,598,412	
6 MOVABLE EQUIPMENT								
7 SUBTOTAL	28,996,358	1,491,500			1,491,500		30,487,858	
8 RECONCILING ITEMS								
9 TOTAL	28,996,358	1,491,500			1,491,500		30,487,858	

PART III - RECONCILIATION OF CAPITAL COST CENTERS
 DESCRIPTION

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS 1	CAPITIALIZED LEASES 2	GROSS ASSETS FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
*								8	
3	NEW CAP REL COSTS-BL	21,889,445		21,889,445	.717973				
4	NEW CAP REL COSTS-MV	8,598,412		8,598,412	.282027				
5	TOTAL	30,487,857		30,487,857	1.000000				

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
*								
3	NEW CAP REL COSTS-BL	929,530	-161,162	232,336			1,000,704	
4	NEW CAP REL COSTS-MV	824,436	126,055				950,491	
5	TOTAL	1,753,966	-35,107	232,336			1,951,195	

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					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
*								
3	NEW CAP REL COSTS-BL	986,547					986,547	
4	NEW CAP REL COSTS-MV	824,436					824,436	
5	TOTAL	1,810,983					1,810,983	

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I
I 14-1320 I
I I

I PERIOD: I PREPARED 5/27/2010
I FROM 1/ 1/2009 I WORKSHEET A-8
I TO 12/31/2009 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO	WKST. A-7 REF.
			COST CENTER	3		
1			**COST CENTER DELETED**		1	
2			**COST CENTER DELETED**		2	
3	A	-81,056	NEW CAP REL COSTS-BLDG &		3	10
4			NEW CAP REL COSTS-MVBLE E		4	
5						
6	B	-24,956	OTHER ADMINISTRATIVE AND		6.01	
7						
8						
9						
10						
11						
12	A-8-2	-1,227,395				
13						
14	A-8-1					
15						
16	B	-87,239	CAFETERIA		12	
17	B	-80,106	NEW CAP REL COSTS-BLDG &		3	10
18	B	-1,510	MEDICAL SUPPLIES CHARGED		55	
19	B	-40,961	DRUGS CHARGED TO PATIENTS		56	
20	B	-1,355	MEDICAL RECORDS & LIBRARY		17	
21						
22						
23						
24						
25	A-8-3/A-8-4		RESPIRATORY THERAPY		49	
26	A-8-3/A-8-4		PHYSICAL THERAPY		50	
27	A-8-3					
28			**COST CENTER DELETED**		89	
29			**COST CENTER DELETED**		1	
30			**COST CENTER DELETED**		2	
31			NEW CAP REL COSTS-BLDG &		3	
32			NEW CAP REL COSTS-MVBLE E		4	
33			**COST CENTER DELETED**		20	
34						
35	A-8-4		**COST CENTER DELETED**		51	
36	A-8-4		**COST CENTER DELETED**		52	
37	A	-6,169	OTHER ADMINISTRATIVE AND		6.01	
38	A	-36,768	OTHER ADMINISTRATIVE AND		6.01	
39						
40	A	-27,581	RURAL HEALTH CLINIC		63.50	
41	A	-4,157	RURAL HEALTH CLINIC 2		63.51	
42	A	-1,264	RURAL HEALTH CLINIC 3		63.52	
43	A	-2,104	PHYSICIANS' PRIVATE OFFIC		98	
44	A	-466,883	ANESTHESIOLOGY		40	
45	A	-119,731	ANESTHESIOLOGY		40	
46	B	-6,643	OTHER ADMINISTRATIVE AND		6.01	
47	B	-3,518	OTHER ADMINISTRATIVE AND		6.01	
48	A	-10,395	OTHER ADMINISTRATIVE AND		6.01	
49	B	-129,215	RURAL HEALTH CLINIC		63.50	
49.01						
49.02						
49.03	B	-10,000	PHYSICIANS' PRIVATE OFFIC		98	
49.04	A	-2,656	OTHER ADMINISTRATIVE AND		6.01	
49.05						
49.06						
49.07	A	-641,877	RADIOLOGY-DIAGNOSTIC		41	
49.08	A	-137,923	RADIOLOGY-DIAGNOSTIC		41	
49.09	A	-10,126	CLINIC		60	
49.10	A	-2,683	CLINIC		60	
49.11	A	-57,017	NEW CAP REL COSTS-BLDG &		3	9
50		-3,221,288				

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 14-1320
I

I PERIOD:
I FROM 1/ 1/2009 I PREPARED 5/27/2010
I TO 12/31/2009 I WORKSHEET A-8-2
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 53	EKG	57,791	57,791					
2 54	EEG	100,124	100,124					
3 59	CARDIAC REHAB	29,444	20,444	9,000				
4 61	ER	1,248,218	1,006,855	241,363				
5 60	OP PSYCH	42,181	42,181					
6								
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27								
28								
29								
30								
101	TOTAL	1,477,758	1,227,395	250,363				

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I NOT A CMS WORKSHEET
 I I TO 12/31/2009 I

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

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	OTHER ADMINIS TRATIVE AND	ADMITTING
	0	3	4	5	6a.00	6.01	6.02
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	1,000,704	1,000,704					
004 NEW CAP REL COSTS-MVBLE E	950,491		950,491				
005 EMPLOYEE BENEFITS	3,494,534	3,254	3,090	3,500,878			
006 01 OTHER ADMINISTRATIVE AND	3,388,280	226,953	215,564	277,803	4,108,600	4,108,600	
006 02 ADMITTING	620,337	21,547	20,465	128,049	790,398	151,481	941,879
008 OPERATION OF PLANT	873,740	98,910	93,946	91,690	1,158,286	221,987	
009 LAUNDRY & LINEN SERVICE	104,024	8,452	8,028		120,504	23,095	
010 HOUSEKEEPING	242,453	5,941	5,643	52,894	306,931	58,824	
011 DIETARY	248,512	25,366	24,093	44,789	342,760	65,690	
012 CAFETERIA	192,105	12,148	11,539	50,346	266,138	51,006	
014 NURSING ADMINISTRATION	538,775	7,524	7,147	143,722	697,168	133,613	
016 PHARMACY	162,450	6,870	6,525	40,484	216,329	41,460	
017 MEDICAL RECORDS & LIBRARY	356,294	18,602	17,669	85,749	478,314	91,669	
018 SOCIAL SERVICE	49,950	1,468	1,394		52,812	10,121	
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	1,426,833	124,249	118,015	377,105	2,046,202	392,157	182,358
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	636,134	54,950	52,192	141,840	885,116	169,633	78,880
040 ANESTHESIOLOGY	23,163	1,132	1,075		25,370	4,862	
041 RADIOLOGY-DIAGNOSTIC	1,508,828	52,439	49,808	193,646	1,804,721	345,877	160,833
044 LABORATORY	1,291,768	28,814	27,369	171,842	1,519,793	291,270	135,441
049 RESPIRATORY THERAPY	159,812	4,624	4,392	39,047	207,875	39,839	18,525
050 PHYSICAL THERAPY	765,548	38,938	36,984	175,203	1,016,673	194,846	90,604
053 ELECTROCARDIOLOGY	48,484	2,263	2,150	11,085	63,982	12,262	5,702
054 ELECTROENCEPHALOGRAPHY	988				988	189	88
055 MEDICAL SUPPLIES CHARGED	330,024				330,024	63,249	29,411
056 DRUGS CHARGED TO PATIENTS	737,928				737,928	141,425	65,763
059 CARDIAC REHAB	87,996	9,505	9,028	19,533	126,062	24,160	11,234
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC	263,462	27,196	25,832	65,102	381,592	73,132	34,007
061 EMERGENCY	1,138,922	40,591	38,554	229,820	1,447,887	277,489	129,033
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	3,521,271	130,394	123,851	845,097	4,620,613	885,536	
063 51 RURAL HEALTH CLINIC 2	242,294	13,262	12,597	51,950	320,103	61,348	
063 52 RURAL HEALTH CLINIC 3	127,584	6,834	6,492	27,914	168,824	32,355	
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	24,533,688	972,226	923,442	3,264,710	24,241,993	3,858,575	941,879
098 NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	1,012,891	28,478	27,049	236,168	1,304,586	250,025	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	25,546,579	1,000,704	950,491	3,500,878	25,546,579	4,108,600	941,879

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET B
 I I TO 12/31/2009 I PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY
	8	9	10	11	12	14	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 OTHER ADMINISTRATIVE AND							
006 02 ADMITTING							
008 OPERATION OF PLANT	1,380,273						
009 LAUNDRY & LINEN SERVICE	17,948	161,547					
010 HOUSEKEEPING	12,616	34,039	412,410				
011 DIETARY	53,861	1,864	16,458	480,633			
012 CAFETERIA	25,795		7,882		350,821		
014 NURSING ADMINISTRATION	15,976		4,882		14,808	866,447	
016 PHARMACY	14,587		4,457		3,468		280,301
017 MEDICAL RECORDS & LIBRARY	39,500		12,069		16,769		
018 SOCIAL SERVICE	3,116		952				
025 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	263,825	43,137	80,613	480,633	53,801	498,182	14
037 ANCILLARY SRVC COST CNTRS							
OPERATING ROOM	116,678	16,372	35,651		16,261	150,570	521
040 ANESTHESIOLOGY	2,403		734		4,171		
041 RADIOLOGY-DIAGNOSTIC	111,346	11,338	34,022		26,419		1,428
044 LABORATORY	61,183	194	18,695		27,890		
049 RESPIRATORY THERAPY	9,819		3,000		5,582		1,812
050 PHYSICAL THERAPY	82,679	21,704	25,263		21,340		171
053 ELECTROCARDIOLOGY	4,806		1,469		1,104		
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							241,922
056 DRUGS CHARGED TO PATIENTS							123
059 CARDIAC REHAB	20,182		6,167		2,014		
060 OUTPAT SERVICE COST CNTRS							
CLINIC	57,748	1,462	17,645		6,922		
061 EMERGENCY	86,190	24,772	26,336		23,510	217,695	364
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	276,873	6,665	84,599		108,070		31,704
063 51 RURAL HEALTH CLINIC 2	28,160		8,605		6,189		1,462
063 52 RURAL HEALTH CLINIC 3	14,512		4,434		2,478		459
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	1,319,803	161,547	393,933	480,633	340,796	866,447	279,980
098 NONREIMBURS COST CENTERS							
PHYSICIANS' PRIVATE OFFIC	60,470		18,477		10,025		321
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	1,380,273	161,547	412,410	480,633	350,821	866,447	280,301

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	18	25	26	27
003 GENERAL SERVICE COST CNTR					
004 NEW CAP REL COSTS-BLDG &					
005 NEW CAP REL COSTS-MVBLE E					
006 EMPLOYEE BENEFITS					
006 01 OTHER ADMINISTRATIVE AND					
006 02 ADMITTING					
008 OPERATION OF PLANT					
009 LAUNDRY & LINEN SERVICE					
010 HOUSEKEEPING					
011 DIETARY					
012 CAFETERIA					
014 NURSING ADMINISTRATION					
016 PHARMACY					
017 MEDICAL RECORDS & LIBRARY	638,321				
018 SOCIAL SERVICE		67,001			
025 INPAT ROUTINE SRVC CNTRS					
ADULTS & PEDIATRICS	33,310	67,001	4,141,233		4,141,233
037 ANCILLARY SRVC COST CNTRS					
OPERATING ROOM	52,039		1,521,721		1,521,721
040 ANESTHESIOLOGY	6,687		44,227		44,227
041 RADIOLOGY-DIAGNOSTIC	195,761		2,691,745		2,691,745
044 LABORATORY	138,598		2,193,064		2,193,064
049 RESPIRATORY THERAPY	4,946		291,398		291,398
050 PHYSICAL THERAPY	54,418		1,507,698		1,507,698
053 ELECTROCARDIOLOGY	13,722		103,047		103,047
054 ELECTROENCEPHALOGRAPHY	2,882		4,147		4,147
055 MEDICAL SUPPLIES CHARGED	25,839		448,523		448,523
056 DRUGS CHARGED TO PATIENTS	53,957		1,240,995		1,240,995
059 CARDIAC REHAB	1,974		191,916		191,916
060 OUTPAT SERVICE COST CNTRS					
CLINIC	4,807		577,315		577,315
061 EMERGENCY	49,381		2,282,657		2,282,657
062 OBSERVATION BEDS (NON-DIS					
063 OTHER OUTPATIENT SERVICE					
063 50 RURAL HEALTH CLINIC			6,014,060		6,014,060
063 51 RURAL HEALTH CLINIC 2			425,867		425,867
063 52 RURAL HEALTH CLINIC 3			223,062		223,062
095 SPEC PURPOSE COST CENTERS	638,321	67,001	23,902,675		23,902,675
SUBTOTALS					
NONREIMBURS COST CENTERS					
098 PHYSICIANS' PRIVATE OFFIC			1,643,904		1,643,904
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 TOTAL	638,321	67,001	25,546,579		25,546,579

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	OTHER ADMINIS TRATIVE AND 6.01	ADMITTING 6.02
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 EMPLOYEE BENEFITS		3,254	3,090	6,344	6,344		
006 01 OTHER ADMINISTRATIVE AND		226,953	215,564	442,517	503	443,020	
006 02 ADMITTING		21,547	20,465	42,012	232	16,334	58,578
008 OPERATION OF PLANT		98,910	93,946	192,856	166	23,936	
009 LAUNDRY & LINEN SERVICE		8,452	8,028	16,480		2,490	
010 HOUSEKEEPING		5,941	5,643	11,584	96	6,343	
011 DIETARY		25,366	24,093	49,459	81	7,083	
012 CAFETERIA		12,148	11,539	23,687	91	5,500	
014 NURSING ADMINISTRATION		7,524	7,147	14,671	260	14,407	
016 PHARMACY		6,870	6,525	13,395	73	4,470	
017 MEDICAL RECORDS & LIBRARY		18,602	17,669	36,271	155	9,884	
018 SOCIAL SERVICE		1,468	1,394	2,862		1,091	
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		124,249	118,015	242,264	683	42,285	11,338
037 ANCELLARY SRVC COST CNTRS OPERATING ROOM		54,950	52,192	107,142	257	18,291	4,906
040 ANESTHESIOLOGY		1,132	1,075	2,207		524	
041 RADIOLOGY-DIAGNOSTIC		52,439	49,808	102,247	351	37,295	10,004
044 LABORATORY		28,814	27,369	56,183	311	31,407	8,424
049 RESPIRATORY THERAPY		4,624	4,392	9,016	71	4,296	1,152
050 PHYSICAL THERAPY		38,938	36,984	75,922	317	21,010	5,635
053 ELECTROCARDIOLOGY		2,263	2,150	4,413	20	1,322	355
054 ELECTROENCEPHALOGRAPHY						20	5
055 MEDICAL SUPPLIES CHARGED						6,820	1,829
056 DRUGS CHARGED TO PATIENTS						15,249	4,090
059 CARDIAC REHAB		9,505	9,028	18,533	35	2,605	699
060 OUTPAT SERVICE COST CNTRS CLINIC		27,196	25,832	53,028	118	7,886	2,115
061 EMERGENCY		40,591	38,554	79,145	416	29,921	8,026
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC		130,394	123,851	254,245	1,535	95,488	
063 51 RURAL HEALTH CLINIC 2		13,262	12,597	25,859	94	6,615	
063 52 RURAL HEALTH CLINIC 3		6,834	6,492	13,326	51	3,489	
095 SPEC PURPOSE COST CENTERS SUBTOTALS		972,226	923,442	1,895,668	5,916	416,061	58,578
098 NONREIMBURS COST CENTERS PHYSICIANS' PRIVATE OFFIC		28,478	27,049	55,527	428	26,959	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		1,000,704	950,491	1,951,195	6,344	443,020	58,578

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET B
 I TO 12/31/2009 I PART III

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY
	8	9	10	11	12	14	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 OTHER ADMINISTRATIVE AND							
006 02 ADMITTING							
008 OPERATION OF PLANT	216,958						
009 LAUNDRY & LINEN SERVICE	2,821	21,791					
010 HOUSEKEEPING	1,983	4,591	24,597				
011 DIETARY	8,466	251	982	66,322			
012 CAFETERIA	4,055		470		33,803		
014 NURSING ADMINISTRATION	2,511		291		1,427	33,567	
016 PHARMACY	2,293		266		334		20,831
017 MEDICAL RECORDS & LIBRARY	6,209		720		1,616		
018 SOCIAL SERVICE	490		57				
025 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	41,469	5,821	4,808	66,322	5,184	19,300	1
037 ANCLLARY SRVC COST CNTRS							
OPERATING ROOM	18,340	2,208	2,126		1,567	5,833	39
040 ANESTHESIOLOGY	378		44		402		
041 RADIOLOGY-DIAGNOSTIC	17,502	1,529	2,029		2,546		106
044 LABORATORY	9,617	26	1,115		2,687		
049 RESPIRATORY THERAPY	1,543		179		538		135
050 PHYSICAL THERAPY	12,996	2,928	1,507		2,056		13
053 ELECTROCARDIOLOGY	755		88		106		
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS							17,978
059 CARDIAC REHAB	3,172		368		194		9
060 OUTPAT SERVICE COST CNTRS							
CLINIC	9,077	197	1,052		667		
061 EMERGENCY	13,548	3,341	1,571		2,265	8,434	27
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	43,521	899	5,045		10,413		2,356
063 51 RURAL HEALTH CLINIC 2	4,426		513		596		109
063 52 RURAL HEALTH CLINIC 3	2,281		264		239		34
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	207,453	21,791	23,495	66,322	32,837	33,567	20,807
098 NONREIMBURS COST CENTERS							
PHYSICIANS' PRIVATE OFFIC	9,505		1,102		966		24
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	216,958	21,791	24,597	66,322	33,803	33,567	20,831

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	18	25	26	27
003 GENERAL SERVICE COST CNTR					
004 NEW CAP REL COSTS-BLDG &					
005 NEW CAP REL COSTS-MVBLE E					
006 EMPLOYEE BENEFITS					
006 01 OTHER ADMINISTRATIVE AND					
006 02 ADMITTING					
008 OPERATION OF PLANT					
009 LAUNDRY & LINEN SERVICE					
010 HOUSEKEEPING					
011 DIETARY					
012 CAFETERIA					
014 NURSING ADMINISTRATION					
016 PHARMACY					
017 MEDICAL RECORDS & LIBRARY	54,855				
018 SOCIAL SERVICE		4,500			
025 INPAT ROUTINE SRVC CNTRS					
ADULTS & PEDIATRICS	2,862	4,500	446,837		446,837
037 ANCILLARY SRVC COST CNTRS					
OPERATING ROOM	4,472		165,181		165,181
040 ANESTHESIOLOGY	575		4,130		4,130
041 RADIOLOGY-DIAGNOSTIC	16,827		190,436		190,436
044 LABORATORY	11,909		121,679		121,679
049 RESPIRATORY THERAPY	425		17,355		17,355
050 PHYSICAL THERAPY	4,676		127,060		127,060
053 ELECTROCARDIOLOGY	1,179		8,238		8,238
054 ELECTROENCEPHALOGRAPHY	248		273		273
055 MEDICAL SUPPLIES CHARGED	2,220		10,869		10,869
056 DRUGS CHARGED TO PATIENTS	4,636		41,953		41,953
059 CARDIAC REHAB	170		25,785		25,785
060 OUTPAT SERVICE COST CNTRS					
CLINIC	413		74,553		74,553
061 EMERGENCY	4,243		150,937		150,937
062 OBSERVATION BEDS (NON-DIS					
063 OTHER OUTPATIENT SERVICE					
063 50 RURAL HEALTH CLINIC			413,502		413,502
063 51 RURAL HEALTH CLINIC 2			38,212		38,212
063 52 RURAL HEALTH CLINIC 3			19,684		19,684
095 SPEC PURPOSE COST CENTERS	54,855	4,500	1,856,684		1,856,684
098 SUBTOTALS					
NONREIMBURS COST CENTERS					
PHYSICIANS' PRIVATE OFFIC			94,511		94,511
101 CROSS FOOT ADJUSTMENTS					
102 NEGATIVE COST CENTER					
103 TOTAL	54,855	4,500	1,951,195		1,951,195

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET B-1
 I I TO 12/31/2009 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	OTHER ADMINIS	ADMITTING	CO
	OSTS-BLDG &	OSTS-MVBLE E	FITS		TRATIVE AND	ST	
	(SQUARE FEET	(SQUARE FEET	(GROSS SALARIES)	6a.01	(ACCUM. COST	(ACCUM.)ST)
	3	4	5		6.01	6.02	
003 GENERAL SERVICE COST							
004 NEW CAP REL COSTS-BLD	113,183						
005 NEW CAP REL COSTS-MVB		113,183					
005 EMPLOYEE BENEFITS	368	368	12,733,216				
006 01 OTHER ADMINISTRATIVE	25,669	25,669	1,010,408	-4,108,600	21,437,979		
006 02 ADMITTING	2,437	2,437	465,733		790,398	10,568,843	
008 OPERATION OF PLANT	11,187	11,187	333,490		1,158,286		
009 LAUNDRY & LINEN SERVI	956	956			120,504		
010 HOUSEKEEPING	672	672	192,384		306,931		
011 DIETARY	2,869	2,869	162,903		342,760		
012 CAFETERIA	1,374	1,374	183,114		266,138		
014 NURSING ADMINISTRATIO	851	851	522,737		697,168		
016 PHARMACY	777	777	147,246		216,329		
017 MEDICAL RECORDS & LIB	2,104	2,104	311,882		478,314		
018 SOCIAL SERVICE	166	166			52,812		
025 INPAT ROUTINE SRVC CN							
ADULTS & PEDIATRICS	14,053	14,053	1,371,586		2,046,202	2,046,202	
037 ANCILLARY SRVC COST C							
OPERATING ROOM	6,215	6,215	515,893		885,116	885,116	
040 ANESTHESIOLOGY	128	128			25,370		
041 RADIOLOGY-DIAGNOSTIC	5,931	5,931	704,319		1,804,721	1,804,721	
044 LABORATORY	3,259	3,259	625,013		1,519,793	1,519,793	
049 RESPIRATORY THERAPY	523	523	142,019		207,875	207,875	
050 PHYSICAL THERAPY	4,404	4,404	637,237		1,016,673	1,016,673	
053 ELECTROCARDIOLOGY	256	256	40,316		63,982	63,982	
054 ELECTROENCEPHALOGRAPH					988	988	
055 MEDICAL SUPPLIES CHAR					330,024	330,024	
056 DRUGS CHARGED TO PATI					737,928	737,928	
059 CARDIAC REHAB	1,075	1,075	71,045		126,062	126,062	
060 OUTPAT SERVICE COST C							
CLINIC	3,076	3,076	236,785		381,592	381,592	
061 EMERGENCY	4,591	4,591	835,890		1,447,887	1,447,887	
062 OBSERVATION BEDS (NON							
063 OTHER OUTPATIENT SERV							
063 50 RURAL HEALTH CLINIC	14,748	14,748	3,073,763		4,620,613		
063 51 RURAL HEALTH CLINIC 2	1,500	1,500	188,948		320,103		
063 52 RURAL HEALTH CLINIC 3	773	773	101,528		168,824		
095 SPEC PURPOSE COST CEN							
SUBTOTALS	109,962	109,962	11,874,239	-4,108,600	20,133,393	10,568,843	
098 NONREIMBURS COST CENT							
PHYSICIANS' PRIVATE O	3,221	3,221	858,977		1,304,586		
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	1,000,704	950,491	3,500,878		4,108,600	941,879	
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER	8.841469		.274941		.191651		
(WRKSHT B, PT I)		8.397825				.089118	
105 COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER			6,344		443,020	58,578	
(WRKSHT B, PT II)							
107 COST TO BE ALLOCATED							
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER			.000498		.020665	.005543	
(WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET B-1
 I I TO 12/31/2009 I

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY
		(SQUARE FEET)	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	(FTE'S)	(NRSNG FTE'S)	(DRUGS)
		8	9	10	11	12	14	16
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	01 OTHER ADMINISTRATIVE							
006	02 ADMITTING							
008	OPERATION OF PLANT	73,522						
009	LAUNDRY & LINEN SERVI	956	12,482					
010	HOUSEKEEPING	672	2,630	71,894				
011	DIETARY	2,869	144	2,869	100			
012	CAFETERIA	1,374		1,374		350,910		
014	NURSING ADMINISTRATIO	851		851		14,812	93,596	
016	PHARMACY	777		777		3,469		826,153
017	MEDICAL RECORDS & LIB	2,104		2,104		16,773		
018	SOCIAL SERVICE	166		166				
025	INPAT ROUTINE SRVC CN ADULTS & PEDIATRICS	14,053	3,333	14,053	100	53,815	53,815	42
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	6,215	1,265	6,215		16,265	16,265	1,535
040	ANESTHESIOLOGY	128		128		4,172		
041	RADIOLOGY-DIAGNOSTIC	5,931	876	5,931		26,426		4,210
044	LABORATORY	3,259	15	3,259		27,897		1
049	RESPIRATORY THERAPY	523		523		5,583		5,342
050	PHYSICAL THERAPY	4,404	1,677	4,404		21,345		505
053	ELECTROCARDIOLOGY	256		256		1,104		
054	ELECTROENCEPHALOGRAPH							
055	MEDICAL SUPPLIES CHAR							713,032
056	DRUGS CHARGED TO PATI							363
059	CARDIAC REHAB	1,075		1,075		2,015		
	OUTPAT SERVICE COST C							
060	CLINIC	3,076	113	3,076		6,924		
061	EMERGENCY	4,591	1,914	4,591		23,516	23,516	1,072
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063	50 RURAL HEALTH CLINIC	14,748	515	14,748		108,096		93,443
063	51 RURAL HEALTH CLINIC 2	1,500		1,500		6,191		4,309
063	52 RURAL HEALTH CLINIC 3	773		773		2,479		1,352
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	70,301	12,482	68,673	100	340,882	93,596	825,206
	NONREIMBURS COST CENT							
098	PHYSICIANS' PRIVATE O	3,221		3,221		10,028		947
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	1,380,273	161,547	412,410	480,633	350,821	866,447	280,301
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	18.773605	12.942397	5.736362	4,806.330000	.999746	9.257308	.339285
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III)	216,958	21,791	24,597	66,322	33,803	33,567	20,831
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	2.950926	1.745794	.342129	663.220000	.096330	.358637	.025214

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET B-1
 I I TO 12/31/2009 I

COST CENTER DESCRIPTION	MEDICAL RECOR SOCIAL SERVIC DS & LIBRARY E	
	(GROSS REV)	(PAT DAYS)
	17	18
GENERAL SERVICE COST		
003 NEW CAP REL COSTS-BLD		
004 NEW CAP REL COSTS-MVB		
005 EMPLOYEE BENEFITS		
006 01 OTHER ADMINISTRATIVE		
006 02 ADMITTING		
008 OPERATION OF PLANT		
009 LAUNDRY & LINEN SERVI		
010 HOUSEKEEPING		
011 DIETARY		
012 CAFETERIA		
014 NURSING ADMINISTRATIO		
016 PHARMACY		
017 MEDICAL RECORDS & LIB	40,780,229	
018 SOCIAL SERVICE		100
INPAT ROUTINE SRVC CN		
025 ADULTS & PEDIATRICS	2,128,010	100
ANCILLARY SRVC COST C		
037 OPERATING ROOM	3,324,556	
040 ANESTHESIOLOGY	427,178	
041 RADIOLOGY-DIAGNOSTIC	12,507,046	
044 LABORATORY	8,854,426	
049 RESPIRATORY THERAPY	315,998	
050 PHYSICAL THERAPY	3,476,511	
053 ELECTROCARDIOLOGY	876,626	
054 ELECTROENCEPHALOGRAPH	184,147	
055 MEDICAL SUPPLIES CHAR	1,650,717	
056 DRUGS CHARGED TO PATI	3,447,049	
059 CARDIAC REHAB	126,136	
OUTPAT SERVICE COST C		
060 CLINIC	307,113	
061 EMERGENCY	3,154,716	
062 OBSERVATION BEDS (NON		
063 OTHER OUTPATIENT SERV		
063 50 RURAL HEALTH CLINIC		
063 51 RURAL HEALTH CLINIC 2		
063 52 RURAL HEALTH CLINIC 3		
SPEC PURPOSE COST CEN		
095 SUBTOTALS	40,780,229	100
NONREIMBURS COST CENT		
098 PHYSICIANS' PRIVATE O		
101 CROSS FOOT ADJUSTMENT		
102 NEGATIVE COST CENTER		
103 COST TO BE ALLOCATED	638,321	67,001
(PER WRKSHT B, PART		
104 UNIT COST MULTIPLIER		670.010000
(WRKSHT B, PT I)	.015653	
105 COST TO BE ALLOCATED		
(PER WRKSHT B, PART		
106 UNIT COST MULTIPLIER		
(WRKSHT B, PT II)		
107 COST TO BE ALLOCATED	54,855	4,500
(PER WRKSHT B, PART		
108 UNIT COST MULTIPLIER		45.000000
(WRKSHT B, PT III)	.001345	

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET C
 I I TO 12/31/2009 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,141,233		4,141,233		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,521,721		1,521,721		
40	ANESTHESIOLOGY	44,227		44,227		
41	RADIOLOGY-DIAGNOSTIC	2,691,745		2,691,745		
44	LABORATORY	2,193,064		2,193,064		
49	RESPIRATORY THERAPY	291,398		291,398		
50	PHYSICAL THERAPY	1,507,698		1,507,698		
53	ELECTROCARDIOLOGY	103,047		103,047		
54	ELECTROENCEPHALOGRAPHY	4,147		4,147		
55	MEDICAL SUPPLIES CHARGED	448,523		448,523		
56	DRUGS CHARGED TO PATIENTS	1,240,995		1,240,995		
59	CARDIAC REHAB	191,916		191,916		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	577,315		577,315		
61	EMERGENCY	2,282,657		2,282,657		
62	OBSERVATION BEDS (NON-DIS	154,980		154,980		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	6,014,060		6,014,060		
63 51	RURAL HEALTH CLINIC 2	425,867		425,867		
63 52	RURAL HEALTH CLINIC 3	223,062		223,062		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	24,057,655		24,057,655		
102	LESS OBSERVATION BEDS	154,980		154,980		
103	TOTAL	23,902,675		23,902,675		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET C
 I I TO 12/31/2009 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,030,091		2,030,091			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	359,563	2,964,993	3,324,556	.457722	.457722	
40	ANESTHESIOLOGY	60,764	366,414	427,178	.103533	.103533	
41	RADIOLOGY-DIAGNOSTIC	639,458	11,867,588	12,507,046	.215218	.215218	
44	LABORATORY	640,834	8,213,591	8,854,425	.247680	.247680	
49	RESPIRATORY THERAPY	138,343	112,396	250,739	1.162157	1.162157	
50	PHYSICAL THERAPY	407,378	3,069,133	3,476,511	.433681	.433681	
53	ELECTROCARDIOLOGY	56,800	819,826	876,626	.117550	.117550	
54	ELECTROENCEPHALOGRAPHY		184,147	184,147	.022520	.022520	
55	MEDICAL SUPPLIES CHARGED	475,585	1,240,391	1,715,976	.261381	.261381	
56	DRUGS CHARGED TO PATIENTS	1,138,966	2,308,083	3,447,049	.360017	.360017	
59	CARDIAC REHAB		126,136	126,136	1.521501	1.521501	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	20	307,093	307,113	1.879813	1.879813	
61	EMERGENCY	65,641	3,089,075	3,154,716	.723570	.723570	
62	OBSERVATION BEDS (NON-DIS	14,082	85,464	99,546	1.556868	1.556868	
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC		5,429,086	5,429,086	1.107748	1.107748	
63 51	RURAL HEALTH CLINIC 2		253,169	253,169	1.682145	1.682145	
63 52	RURAL HEALTH CLINIC 3		102,497	102,497	2.176278	2.176278	
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	6,027,525	40,539,082	46,566,607			
102	LESS OBSERVATION BEDS						
103	TOTAL	6,027,525	40,539,082	46,566,607			

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,141,233		4,141,233		
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	1,521,721		1,521,721		
40	ANESTHESIOLOGY	44,227		44,227		
41	RADIOLOGY-DIAGNOSTIC	2,691,745		2,691,745		
44	LABORATORY	2,193,064		2,193,064		
49	RESPIRATORY THERAPY	291,398		291,398		
50	PHYSICAL THERAPY	1,507,698		1,507,698		
53	ELECTROCARDIOLOGY	103,047		103,047		
54	ELECTROENCEPHALOGRAPHY	4,147		4,147		
55	MEDICAL SUPPLIES CHARGED	448,523		448,523		
56	DRUGS CHARGED TO PATIENTS	1,240,995		1,240,995		
59	CARDIAC REHAB OUTPAT SERVICE COST CNTRS	191,916		191,916		
60	CLINIC	577,315		577,315		
61	EMERGENCY	2,282,657		2,282,657		
62	OBSERVATION BEDS (NON-DIS	154,980		154,980		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	6,014,060		6,014,060		
63 51	RURAL HEALTH CLINIC 2	425,867		425,867		
63 52	RURAL HEALTH CLINIC 3	223,062		223,062		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	24,057,655		24,057,655		
102	LESS OBSERVATION BEDS	154,980		154,980		
103	TOTAL	23,902,675		23,902,675		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO:
I 14-1320
I

I PERIOD:
I FROM 1/ 1/2009
I TO 12/31/2009

I PREPARED 5/27/2010
I WORKSHEET C
I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,030,091		2,030,091			
	ANCLLARY SRVC COST CNTRS						
37	OPERATING ROOM	359,563	2,964,993	3,324,556	.457722	.457722	
40	ANESTHESIOLOGY	60,764	366,414	427,178	.103533	.103533	
41	RADIOLOGY-DIAGNOSTIC	639,458	11,867,588	12,507,046	.215218	.215218	
44	LABORATORY	640,834	8,213,591	8,854,425	.247680	.247680	
49	RESPIRATORY THERAPY	138,343	112,396	250,739	1.162157	1.162157	
50	PHYSICAL THERAPY	407,378	3,069,133	3,476,511	.433681	.433681	
53	ELECTROCARDIOLOGY	56,800	819,826	876,626	.117550	.117550	
54	ELECTROENCEPHALOGRAPHY		184,147	184,147	.022520	.022520	
55	MEDICAL SUPPLIES CHARGED	475,585	1,240,391	1,715,976	.261381	.261381	
56	DRUGS CHARGED TO PATIENTS	1,138,966	2,308,083	3,447,049	.360017	.360017	
59	CARDIAC REHAB		126,136	126,136	1.521501	1.521501	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	20	307,093	307,113	1.879813	1.879813	
61	EMERGENCY	65,641	3,089,075	3,154,716	.723570	.723570	
62	OBSERVATION BEDS (NON-DIS	14,082	85,464	99,546	1.556868	1.556868	
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC		5,429,086	5,429,086	1.107748	1.107748	
63 51	RURAL HEALTH CLINIC 2		253,169	253,169	1.682145	1.682145	
63 52	RURAL HEALTH CLINIC 3		102,497	102,497	2.176278	2.176278	
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	6,027,525	40,539,082	46,566,607			
102	LESS OBSERVATION BEDS						
103	TOTAL	6,027,525	40,539,082	46,566,607			

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	1,521,721	165,181	1,356,540			1,521,721
40	OPERATING ROOM	44,227	4,130	40,097			44,227
41	ANESTHESIOLOGY	2,691,745	190,436	2,501,309			2,691,745
44	RADIOLOGY-DIAGNOSTIC	2,193,064	121,679	2,071,385			2,193,064
49	LABORATORY	291,398	17,355	274,043			291,398
50	RESPIRATORY THERAPY	1,507,698	127,060	1,380,638			1,507,698
53	PHYSICAL THERAPY	103,047	8,238	94,809			103,047
54	ELECTROCARDIOLOGY	4,147	273	3,874			4,147
55	ELECTROENCEPHALOGRAPHY	448,523	10,869	437,654			448,523
56	MEDICAL SUPPLIES CHARGED	1,240,995	41,953	1,199,042			1,240,995
59	DRUGS CHARGED TO PATIENTS	191,916	25,785	166,131			191,916
	CARDIAC REHAB						
60	OUTPAT SERVICE COST CNTRS	577,315	74,553	502,762			577,315
61	CLINIC	2,282,657	150,937	2,131,720			2,282,657
62	EMERGENCY	154,980		154,980			154,980
63	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE	6,014,060	413,502	5,600,558			6,014,060
63	50 RURAL HEALTH CLINIC	425,867	38,212	387,655			425,867
63	51 RURAL HEALTH CLINIC 2	223,062	19,684	203,378			223,062
63	52 RURAL HEALTH CLINIC 3						
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	19,916,422	1,409,847	18,506,575			19,916,422
102	LESS OBSERVATION BEDS	154,980		154,980			154,980
103	TOTAL	19,761,442	1,409,847	18,351,595			19,761,442

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	3,324,556	.457722	.457722
40	ANESTHESIOLOGY	427,178	.103533	.103533
41	RADIOLOGY-DIAGNOSTIC	12,507,046	.215218	.215218
44	LABORATORY	8,854,425	.247680	.247680
49	RESPIRATORY THERAPY	250,739	1.162157	1.162157
50	PHYSICAL THERAPY	3,476,511	.433681	.433681
53	ELECTROCARDIOLOGY	876,626	.117550	.117550
54	ELECTROENCEPHALOGRAPHY	184,147	.022520	.022520
55	MEDICAL SUPPLIES CHARGED	1,715,976	.261381	.261381
56	DRUGS CHARGED TO PATIENTS	3,447,049	.360017	.360017
59	CARDIAC REHAB	126,136	1.521501	1.521501
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	307,113	1.879813	1.879813
61	EMERGENCY	3,154,716	.723570	.723570
62	OBSERVATION BEDS (NON-DIS	99,546	1.556868	1.556868
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	5,429,086	1.107748	1.107748
63	51 RURAL HEALTH CLINIC 2	253,169	1.682145	1.682145
63	52 RURAL HEALTH CLINIC 3	102,497	2.176278	2.176278
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	44,536,516		
102	LESS OBSERVATION BEDS	99,546		
103	TOTAL	44,436,970		

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						1,521,721
	OPERATING ROOM	1,521,721	165,181	1,356,540			1,521,721
40	ANESTHESIOLOGY	44,227	4,130	40,097			44,227
41	RADIOLOGY-DIAGNOSTIC	2,691,745	190,436	2,501,309			2,691,745
44	LABORATORY	2,193,064	121,679	2,071,385			2,193,064
49	RESPIRATORY THERAPY	291,398	17,355	274,043			291,398
50	PHYSICAL THERAPY	1,507,698	127,060	1,380,638			1,507,698
53	ELECTROCARDIOLOGY	103,047	8,238	94,809			103,047
54	ELECTROENCEPHALOGRAPHY	4,147	273	3,874			4,147
55	MEDICAL SUPPLIES CHARGED	448,523	10,869	437,654			448,523
56	DRUGS CHARGED TO PATIENTS	1,240,995	41,953	1,199,042			1,240,995
59	CARDIAC REHAB	191,916	25,785	166,131			191,916
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	577,315	74,553	502,762			577,315
61	EMERGENCY	2,282,657	150,937	2,131,720			2,282,657
62	OBSERVATION BEDS (NON-DIS	154,980		154,980			154,980
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	6,014,060	413,502	5,600,558			6,014,060
63	51 RURAL HEALTH CLINIC 2	425,867	38,212	387,655			425,867
63	52 RURAL HEALTH CLINIC 3	223,062	19,684	203,378			223,062
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	19,916,422	1,409,847	18,506,575			19,916,422
102	LESS OBSERVATION BEDS	154,980		154,980			154,980
103	TOTAL	19,761,442	1,409,847	18,351,595			19,761,442

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	3,324,556	.457722	.457722
40	ANESTHESIOLOGY	427,178	.103533	.103533
41	RADIOLOGY-DIAGNOSTIC	12,507,046	.215218	.215218
44	LABORATORY	8,854,425	.247680	.247680
49	RESPIRATORY THERAPY	250,739	1.162157	1.162157
50	PHYSICAL THERAPY	3,476,511	.433681	.433681
53	ELECTROCARDIOLOGY	876,626	.117550	.117550
54	ELECTROENCEPHALOGRAPHY	184,147	.022520	.022520
55	MEDICAL SUPPLIES CHARGED	1,715,976	.261381	.261381
56	DRUGS CHARGED TO PATIENTS	3,447,049	.360017	.360017
59	CARDIAC REHAB	126,136	1.521501	1.521501
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	307,113	1.879813	1.879813
61	EMERGENCY	3,154,716	.723570	.723570
62	OBSERVATION BEDS (NON-DIS	99,546	1.556868	1.556868
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	5,429,086	1.107748	1.107748
63	51 RURAL HEALTH CLINIC 2	253,169	1.682145	1.682145
63	52 RURAL HEALTH CLINIC 3	102,497	2.176278	2.176278
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	44,536,516		
102	LESS OBSERVATION BEDS	99,546		
103	TOTAL	44,436,970		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET C
 I I TO 12/31/2009 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,517,437	3,198,521			
40	ANESTHESIOLOGY	48,718	413,287			
41	RADIOLOGY-DIAGNOSTIC	2,527,453	11,243,668			
44	LABORATORY	2,129,487	8,477,156			
49	RESPIRATORY THERAPY	285,925	287,117			
50	PHYSICAL THERAPY	1,595,754	3,424,009			
53	ELECTROCARDIOLOGY	106,113	873,738			
54	ELECTROENCEPHALOGRAPHY	5,481	265,220			
55	MEDICAL SUPPLIES CHARGED	404,539	1,676,852			
56	DRUGS CHARGED TO PATIENTS	1,402,901	4,048,114			
59	CARDIAC REHAB	179,436	159,273			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	515,388	317,878			
61	EMERGENCY	2,180,327	2,882,766			
62	OBSERVATION BEDS (NON-DIS	141,008	110,621			
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	6,008,828	4,938,035			
63	51 RURAL HEALTH CLINIC 2	386,554	249,931			
63	52 RURAL HEALTH CLINIC 3	222,033	98,356			
	OTHER REIMBURS COST CNTRS					
101	TOTAL	19,657,382	42,664,542			

COMPUTATION OF OUTPATIENT COST PER VISIT -
 RURAL PRIMARY CARE HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM	1,517,437		1,517,437	3,198,521			
40	ANESTHESIOLOGY	48,718		48,718	413,287			
41	RADIOLOGY-DIAGNOSTIC	2,527,453		2,527,453	11,243,668			
44	LABORATORY	2,129,487		2,129,487	8,477,156			
49	RESPIRATORY THERAPY	285,925		285,925	287,117			
50	PHYSICAL THERAPY	1,595,754		1,595,754	3,424,009			
53	ELECTROCARDIOLOGY	106,113	53,710	159,823	873,738			
54	ELECTROENCEPHALOGRAPHY	5,481	101,305	106,786	265,220			
55	MEDICAL SUPPLIES CHARGED	404,539		404,539	1,676,852			
56	DRUGS CHARGED TO PATIENTS	1,402,901		1,402,901	4,048,114			
59	CARDIAC REHAB	179,436	20,480	199,916	159,273			
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	515,388		515,388	317,878			
61	EMERGENCY	2,180,327	901,744	3,082,071	2,882,766			
62	OBSERVATION BEDS (NON-DIS	141,008		141,008	110,621			
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
63 51	RURAL HEALTH CLINIC 2							
63 52	RURAL HEALTH CLINIC 3							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	13,039,967	1,077,239	14,117,206	37,378,220			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge	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	Radialogy
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.457722		.457722		
40 ANESTHESIOLOGY	.103533		.103533		
41 RADIOLOGY-DIAGNOSTIC	.215218		.215218		
44 LABORATORY	.247680		.247680		
49 RESPIRATORY THERAPY	1.162157		1.162157		
50 PHYSICAL THERAPY	.433681		.433681		
53 ELECTROCARDIOLOGY	.117550		.117550		
54 ELECTROENCEPHALOGRAPHY	.022520		.022520		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.261381		.261381		
56 DRUGS CHARGED TO PATIENTS	.360017		.360017		
59 CARDIAC REHAB	1.521501		1.521501		
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC	1.879813		1.879813		
61 EMERGENCY	.723570		.723570		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.556868		1.556868		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES					

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		1,045,048			
40 ANESTHESIOLOGY		123,397			
41 RADIOLOGY-DIAGNOSTIC		3,566,158			
44 LABORATORY		3,147,501			
49 RESPIRATORY THERAPY		31,226			
50 PHYSICAL THERAPY		977,843			
53 ELECTROCARDIOLOGY		305,173			
54 ELECTROENCEPHALOGRAPHY		7,913			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		529,804			
56 DRUGS CHARGED TO PATIENTS		1,065,893			
59 CARDIAC REHAB		81,716			
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC		177,350			
61 EMERGENCY		891,082			
62 OBSERVATION BEDS (NON-DISTINCT PART)		36,763			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
101 SUBTOTAL		11,986,867			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		11,986,867			

TITLE XVIII, PART B

HOSPITAL

	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	478,341		
40 ANESTHESIOLOGY	12,776		
41 RADIOLOGY-DIAGNOSTIC	767,501		
44 LABORATORY	779,573		
49 RESPIRATORY THERAPY	36,290		
50 PHYSICAL THERAPY	424,072		
53 ELECTROCARDIOLOGY	35,873		
54 ELECTROENCEPHALOGRAPHY	178		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	138,481		
56 DRUGS CHARGED TO PATIENTS	383,740		
59 CARDIAC REHAB	124,331		
OUTPAT SERVICE COST CNTRS			
60 CLINIC	333,385		
61 EMERGENCY	644,760		
62 OBSERVATION BEDS (NON-DISTINCT PART)	57,235		
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
63 51 RURAL HEALTH CLINIC 2			
63 52 RURAL HEALTH CLINIC 3			
101 SUBTOTAL	4,216,536		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	4,216,536		

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					624,387
37 OPERATING ROOM	.457722				66,664
40 ANESTHESIOLOGY	.103533				2,739,225
41 RADIOLOGY-DIAGNOSTIC	.215218				1,439,232
44 LABORATORY	.247680				23,306
49 RESPIRATORY THERAPY	1.162157				517,257
50 PHYSICAL THERAPY	.433681				73,872
53 ELECTROCARDIOLOGY	.117550				49,065
54 ELECTROENCEPHALOGRAPHY	.022520				81,081
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.261381				336,334
56 DRUGS CHARGED TO PATIENTS	.360017				
59 CARDIAC REHAB	1.521501				
OUTPAT SERVICE COST CNTRS					4,708
60 CLINIC	1.879813				946,494
61 EMERGENCY	.723570				14,774
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.556868				
63 OTHER OUTPATIENT SERVICE COST CENTER					25,604
63 50 RURAL HEALTH CLINIC	1.107748				
63 51 RURAL HEALTH CLINIC 2	1.682145				
63 52 RURAL HEALTH CLINIC 3	2.176278				
101 SUBTOTAL					6,942,003
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					6,942,003
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

TITLE XIX - O/P

HOSPITAL

Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
(A)	5.01	5.02	5.03	6	7
37 OPERATING ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
53 ELECTROCARDIOLOGY					
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
59 CARDIAC REHAB					
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

TITLE XIX - O/P	HOSPITAL	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
Cost Center Description		8	9	9.01	9.02	9.03
(A) ANCILLARY SRVC COST CNTRS						
37 OPERATING ROOM			285,796			
40 ANESTHESIOLOGY			6,902			
41 RADIOLOGY-DIAGNOSTIC			589,531			
44 LABORATORY			356,469			
49 RESPIRATORY THERAPY			27,085			
50 PHYSICAL THERAPY			224,325			
53 ELECTROCARDIOLOGY			8,684			
54 ELECTROENCEPHALOGRAPHY			1,105			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS			21,193			
56 DRUGS CHARGED TO PATIENTS			121,086			
59 CARDIAC REHAB						
OUTPAT SERVICE COST CNTRS						
60 CLINIC			8,850			
61 EMERGENCY			684,855			
62 OBSERVATION BEDS (NON-DISTINCT PART)			23,001			
63 OTHER OUTPATIENT SERVICE COST CENTER						
63 50 RURAL HEALTH CLINIC			28,363			
63 51 RURAL HEALTH CLINIC 2						
63 52 RURAL HEALTH CLINIC 3						
101 SUBTOTAL			2,387,245			
102 CRNA CHARGES						
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES						
104 NET CHARGES			2,387,245			

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

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,556
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,124
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,124
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	606
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3,826
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,350
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	606
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	112.36
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	112.36
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,141,233
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	429,889
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,253,728
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,887,505

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,043,573
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,043,573
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.412969
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	962.13
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,887,505

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,359.47
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,835,285
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,835,285

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT					
HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					609,050
49 TOTAL PROGRAM INPATIENT COSTS					2,444,335

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 823,839
 REPORTING PERIOD (SEE INSTRUCTIONS)
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS)
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 823,839
 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE
 COST REPORTING PERIOD
 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE
 COST REPORTING PERIOD
 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2009 I PART III
 I 14-1320 I I

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 114
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,359.47
- 85 OBSERVATION BED COST 154,980

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2009 I
 I 14-1320 I

TITLE XVIII, PART A HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		908,617	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.457722	113,356	51,886
40	ANESTHESIOLOGY	.103533	17,789	1,842
41	RADIOLOGY-DIAGNOSTIC	.215218	322,449	69,397
44	LABORATORY	.247680	343,248	85,016
49	RESPIRATORY THERAPY	1.162157	69,692	80,993
50	PHYSICAL THERAPY	.433681	108,755	47,165
53	ELECTROCARDIOLOGY	.117550	33,911	3,986
54	ELECTROENCEPHALOGRAPHY	.022520		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.261381	231,780	60,583
56	DRUGS CHARGED TO PATIENTS	.360017	576,432	207,525
59	CARDIAC REHAB OUTPAT SERVICE COST CNTRS	1.521501		
60	CLINIC	1.879813		
61	EMERGENCY	.723570	908	657
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.556868		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
63 51	RURAL HEALTH CLINIC 2			
63 52	RURAL HEALTH CLINIC 3			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		1,818,320	609,050
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,818,320	

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.457722		
40	ANESTHESIOLOGY	.103533		
41	RADIOLOGY-DIAGNOSTIC	.215218	8,309	1,788
44	LABORATORY	.247680	30,145	7,466
49	RESPIRATORY THERAPY	1.162157	17,214	20,005
50	PHYSICAL THERAPY	.433681	237,879	103,164
53	ELECTROCARDIOLOGY	.117550	531	62
54	ELECTROENCEPHALOGRAPHY	.022520		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.261381	24,474	6,397
56	DRUGS CHARGED TO PATIENTS	.360017	117,567	42,326
59	CARDIAC REHAB	1.521501		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1.879813		
61	EMERGENCY	.723570		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.556868		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
63 51	RURAL HEALTH CLINIC 2			
63 52	RURAL HEALTH CLINIC 3			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		436,119	181,208
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		436,119	

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		123,753	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.457722	127,433	58,329
40	ANESTHESIOLOGY	.103533	14,822	1,535
41	RADIOLOGY-DIAGNOSTIC	.215218	79,327	17,073
44	LABORATORY	.247680	70,667	17,503
49	RESPIRATORY THERAPY	1.162157	15,682	18,225
50	PHYSICAL THERAPY	.433681	9,350	4,055
53	ELECTROCARDIOLOGY	.117550	9,293	1,092
54	ELECTROENCEPHALOGRAPHY	.022520		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.261381	14,511	3,793
56	DRUGS CHARGED TO PATIENTS	.360017	122,669	44,163
59	CARDIAC REHAB OUTPAT SERVICE COST CNTRS	1.521501		
60	CLINIC	1.879813		
61	EMERGENCY	.723570	20,010	14,479
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.556868	3,430	5,340
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC	1.107748		
63 51	RURAL HEALTH CLINIC 2	1.682145		
63 52	RURAL HEALTH CLINIC 3	2.176278		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		487,194	185,587
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		487,194	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 4,216,536
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.
 1.04 LINE 1.01 TIMES LINE 1.03.
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)
 1.07 ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.
 2 INTERNS AND RESIDENTS
 3 ORGAN ACQUISITIONS
 4 COST OF TEACHING PHYSICIANS
 5 TOTAL COST (SEE INSTRUCTIONS) 4,216,536

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES
 6 ANCILLARY SERVICE CHARGES
 7 INTERNS AND RESIDENTS SERVICE CHARGES
 8 ORGAN ACQUISITION CHARGES
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.
 10 TOTAL REASONABLE CHARGES
 CUSTOMARY CHARGES
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).
 13 RATIO OF LINE 11 TO LINE 12
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 4,258,701
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 39,545
 18.01 CAH ACTUAL BILLED COINSURANCE 1,771,151
 LINE 17.01 (SEE INSTRUCTIONS)
 19 SUBTOTAL (SEE INSTRUCTIONS) 2,448,005
 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)
 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
 22 ESRD DIRECT MEDICAL EDUCATION COSTS
 23 SUBTOTAL 2,448,005
 24 PRIMARY PAYER PAYMENTS 633
 25 SUBTOTAL 2,447,372

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD
 27 BAD DEBTS (SEE INSTRUCTIONS) 622,829
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 622,829
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES
 28 SUBTOTAL 3,070,201
 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 3,070,201
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
 34 INTERIM PAYMENTS 2,942,968
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY) 127,233
 35 BALANCE DUE PROVIDER/PROGRAM
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

TO BE COMPLETED BY CONTRACTOR

50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)
 51 OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)
 52 THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY
 53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)
 54 TOTAL (SUM OF LINES 51 AND 53)

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,955,700		2,537,527
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.		69,116		491,775
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01 8/10/2009	4,905	12/15/2009	204,655
ADJUSTMENTS TO PROVIDER	.02 12/15/2009	17,832		
ADJUSTMENTS TO PROVIDER	.03 12/15/2009	22,034		
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROGRAM	.50 8/10/2009	49,392	8/10/2009	34,125
ADJUSTMENTS TO PROGRAM	.51		8/10/2009	126,260
ADJUSTMENTS TO PROGRAM	.52		12/15/2009	130,604
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99	-4,621		-86,334
4 TOTAL INTERIM PAYMENTS		2,020,195		2,942,968
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	.01 250,106		127,233
	SETTLEMENT TO PROGRAM	.02		
7 TOTAL MEDICARE PROGRAM LIABILITY		2,270,301		3,070,201

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2009 I
 I 14-Z320 I I

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		907,960		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	8/10/2009	9,938		
ADJUSTMENTS TO PROVIDER .02	12/15/2009	24,120		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		34,058		NONE
4 TOTAL INTERIM PAYMENTS		942,018		
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	70,142		
	SETTLEMENT TO PROGRAM .02			
7 TOTAL MEDICARE PROGRAM LIABILITY		1,012,160		

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I
 I COMPONENT NO: I TO 12/31/2009 I WORKSHEET E-2
 I 14-Z320 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	832,077	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	183,020	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	606	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,015,097	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,015,097	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,015,097	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	2,937	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,012,160	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,012,160	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	942,018	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	70,142	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2009 I PART II
 I 14-1320 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,444,335
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,444,335
5	PRIMARY PAYER PAYMENTS	3,331
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,465,414

COMPUTATION OF LESSER OF COST OR CHARGES

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

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	2,465,414
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	289,978
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,175,436
23	COINSURANCE	
24	SUBTOTAL	2,175,436
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	94,865
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	94,865
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	2,270,301
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	2,270,301
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,020,195
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	250,106
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	4,422,016			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	4,999,069			
5 OTHER RECEIVABLES				
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7 INVENTORY	504,548			
8 PREPAID EXPENSES	471,136			
9 OTHER CURRENT ASSETS	34,491			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	10,431,260			
FIXED ASSETS				
12 LAND				
12.01 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	15,128,983			
14.01 LESS ACCUMULATED DEPRECIATION				
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT				
18.01 LESS ACCUMULATED DEPRECIATION				
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	15,128,983			
OTHER ASSETS				
22 INVESTMENTS	9,887,622			
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	168,724			
26 TOTAL OTHER ASSETS	10,056,346			
27 TOTAL ASSETS	35,616,589			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	789,659			
29 SALARIES, WAGES & FEES PAYABLE	1,253,093			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	312,474			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	233,464			
35 OTHER CURRENT LIABILITIES				
36 TOTAL CURRENT LIABILITIES	2,588,690			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE	4,434,638			
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	4,434,638			
43 TOTAL LIABILITIES	7,023,328			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	28,593,261			
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	28,593,261			
52 TOTAL LIABILITIES AND FUND BALANCES	35,616,589			

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		26,262,135		
2	NET INCOME (LOSS)		1,933,757		
3	TOTAL		28,195,892		
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5	ADDITIONS (CREDIT ADJUSTM	397,369			
6					
7					
8					
9					
10	TOTAL ADDITIONS		397,369		
11	SUBTOTAL		28,593,261		
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13	DEDUCTIONS (DEBIT ADJUSTM				
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		28,593,261		

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

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	2,043,573		2,043,573
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,043,573		2,043,573
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	2,043,573		2,043,573
17 00 ANCILLARY SERVICES	3,983,352	34,753,303	38,736,655
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC		5,429,086	5,429,086
18 51 RURAL HEALTH CLINIC 2		253,169	253,169
18 52 RURAL HEALTH CLINIC 3		102,497	102,497
24 00	376,768	8,394,286	8,771,054
25 00 TOTAL PATIENT REVENUES	6,403,693	48,932,341	55,336,034

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		28,767,867	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)	3,086,877		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		3,086,877	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		31,854,744	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET G-3
 I I TO 12/31/2009 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	55,336,034
2	LESS: ALLOWANCES AND DISCOUNTS ON	23,658,556
3	NET PATIENT REVENUES	31,677,478
4	LESS: TOTAL OPERATING EXPENSES	31,854,744
5	NET INCOME FROM SERVICE TO PATIENT	-177,266
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	461,809
24	OTHER (SPECIFY)	1,649,214
25	TOTAL OTHER INCOME	2,111,023
26	TOTAL	1,933,757
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	1,933,757

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

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2009 I
I 14-3987 I I

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2	1,638,841		1,638,841	
3	130,782		130,782	
4				
5	585,147		585,147	
6				
7				
8	82		82	
9				
10	2,354,852		2,354,852	
COSTS UNDER AGREEMENT				
11				
12				
13				
14				
OTHER HEALTH CARE COSTS				
15		3,836	3,836	
16				
17				
18		99,361	99,361	
19				
20				
21		103,197	103,197	
22	2,354,852	103,197	2,458,049	
COSTS OTHER THAN RHC/FQHC SERVICES				
23		93,443	93,443	
24				
25				
26		163,897	163,897	
27				
28		257,340	257,340	
FACILITY OVERHEAD				
29				
30	718,911	267,055	985,966	-23,288
31	718,911	267,055	985,966	-23,288
32	3,073,763	627,592	3,701,355	-23,288

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
1 PHYSICIAN	1,638,841		1,638,841
2 PHYSICIAN ASSISTANT			
3 NURSE PRACTITIONER	130,782		130,782
4 VISITING NURSE			
5 OTHER NURSE	585,147		585,147
6 CLINICAL PSYCHOLOGIST			
7 CLINICAL SOCIAL WORKER			
8 LABORATORY TECHNICIAN	82		82
9 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	2,354,852		2,354,852
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT			
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	3,836		3,836
17 TRANSPORTATION (HEALTH CARE STAFF)			
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE	99,361		99,361
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	103,197		103,197
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,458,049		2,458,049
23 COSTS OTHER THAN RHC/FQHC SERVICES			
23 PHARMACY	93,443		93,443
24 DENTAL			
25 OPTOMETRY			
26 ALL OTHER NONREIMBURSABLE COSTS	163,897		163,897
27 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	257,340		257,340
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	962,678	-156,796	805,882
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	962,678	-156,796	805,882
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	3,678,067	-156,796	3,521,271

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

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2009 I
I 14-3989 I I

RHC 2

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN	12,000		12,000	
3 PHYSICIAN ASSISTANT				
4 NURSE PRACTITIONER	97,551		97,551	
5 VISITING NURSE				
6 OTHER NURSE	41,957		41,957	
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 LABORATORY TECHNICIAN	10		10	
10 OTHER FACILITY HEALTH CARE STAFF COSTS				
10 SUBTOTAL (SUM OF LINES 1-9)	151,518		151,518	
11 COSTS UNDER AGREEMENT				
12 PHYSICIAN SERVICES UNDER AGREEMENT				
13 PHYSICIAN SUPERVISION UNDER AGREEMENT				
14 OTHER COSTS UNDER AGREEMENT				
14 SUBTOTAL (SUM OF LINES 11-13)				
15 OTHER HEALTH CARE COSTS				
16 MEDICAL SUPPLIES		177	177	
17 TRANSPORTATION (HEALTH CARE STAFF)				
18 DEPRECIATION-MEDICAL EQUIPMENT		414	414	
19 PROFESSIONAL LIABILITY INSURANCE				
20 OTHER HEALTH CARE COSTS				
21 ALLOWABLE GME COSTS				
21 SUBTOTAL (SUM OF LINES 15-20)		591	591	
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	151,518	591	152,109	
23 COSTS OTHER THAN RHC/FQHC SERVICES				
24 PHARMACY		4,309	4,309	
25 DENTAL				
26 OPTOMETRY				
27 ALL OTHER NONREIMBURSABLE COSTS		20,386	20,386	
28 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		24,695	24,695	
29 FACILITY OVERHEAD				
30 FACILITY COSTS				
30 ADMINISTRATIVE COSTS	37,430	61,559	98,989	-29,342
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	37,430	61,559	98,989	-29,342
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	188,948	86,845	275,793	-29,342

RHC 2

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	12,000		12,000
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	97,551		97,551
5 VISITING NURSE			
6 OTHER NURSE	41,957		41,957
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER	10		10
9 LABORATORY TECHNICIAN			
10 OTHER FACILITY HEALTH CARE STAFF COSTS	151,518		151,518
11 SUBTOTAL (SUM OF LINES 1-9)			
12 COSTS UNDER AGREEMENT			
13 PHYSICIAN SERVICES UNDER AGREEMENT			
14 PHYSICIAN SUPERVISION UNDER AGREEMENT			
15 OTHER COSTS UNDER AGREEMENT			
16 SUBTOTAL (SUM OF LINES 11-13)			
17 OTHER HEALTH CARE COSTS			
18 MEDICAL SUPPLIES	177		177
19 TRANSPORTATION (HEALTH CARE STAFF)			
20 DEPRECIATION-MEDICAL EQUIPMENT	414		414
21 PROFESSIONAL LIABILITY INSURANCE			
22 OTHER HEALTH CARE COSTS			
23 ALLOWABLE GME COSTS	591		591
24 SUBTOTAL (SUM OF LINES 15-20)	591		591
25 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	152,109		152,109
26 COSTS OTHER THAN RHC/FQHC SERVICES			
27 PHARMACY	4,309		4,309
28 DENTAL			
29 OPTOMETRY			
30 ALL OTHER NONREIMBURSABLE COSTS	20,386		20,386
31 NONALLOWABLE GME COSTS			
32 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	24,695		24,695
33 FACILITY OVERHEAD			
34 FACILITY COSTS			
35 ADMINISTRATIVE COSTS	69,647	-4,157	65,490
36 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	69,647	-4,157	65,490
37 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	246,451	-4,157	242,294

RHC 3

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN	8,004		8,004	
3 PHYSICIAN ASSISTANT				
4 NURSE PRACTITIONER	56,585		56,585	
5 VISITING NURSE				
6 OTHER NURSE	19,903		19,903	
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER	4		4	
9 LABORATORY TECHNICIAN				
10 OTHER FACILITY HEALTH CARE STAFF COSTS				
11 SUBTOTAL (SUM OF LINES 1-9)	84,496		84,496	
12 COSTS UNDER AGREEMENT				
13 PHYSICIAN SERVICES UNDER AGREEMENT				
14 PHYSICIAN SUPERVISION UNDER AGREEMENT				
15 OTHER COSTS UNDER AGREEMENT				
16 SUBTOTAL (SUM OF LINES 11-13)				
17 OTHER HEALTH CARE COSTS				
18 MEDICAL SUPPLIES		56	56	
19 TRANSPORTATION (HEALTH CARE STAFF)				
20 DEPRECIATION-MEDICAL EQUIPMENT				
21 PROFESSIONAL LIABILITY INSURANCE		542	542	
22 OTHER HEALTH CARE COSTS				
23 ALLOWABLE GME COSTS				
24 SUBTOTAL (SUM OF LINES 15-20)		598	598	
25 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	84,496	598	85,094	
26 COSTS OTHER THAN RHC/FQHC SERVICES				
27 PHARMACY		1,352	1,352	
28 DENTAL				
29 OPTOMETRY				
30 ALL OTHER NONREIMBURSABLE COSTS		6,605	6,605	
31 NONALLOWABLE GME COSTS				
32 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		7,957	7,957	
33 FACILITY OVERHEAD				
34 FACILITY COSTS				
35 ADMINISTRATIVE COSTS	17,032	35,923	52,955	-17,158
36 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	17,032	35,923	52,955	-17,158
37 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	101,528	44,478	146,006	-17,158

RHC 3

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	8,004		8,004
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	56,585		56,585
5 VISITING NURSE			
6 OTHER NURSE	19,903		19,903
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER	4		4
9 LABORATORY TECHNICIAN			
10 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	84,496		84,496
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT			
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	56		56
17 TRANSPORTATION (HEALTH CARE STAFF)			
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE	542		542
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS	598		598
22 SUBTOTAL (SUM OF LINES 15-20)	598		598
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	85,094		85,094
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY	1,352		1,352
25 DENTAL			
26 OPTOMETRY			
27 ALL OTHER NONREIMBURSABLE COSTS	6,605		6,605
28 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	7,957		7,957
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
31 ADMINISTRATIVE COSTS	35,797	-1,264	34,533
32 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	35,797	-1,264	34,533
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	128,848	-1,264	127,584

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-2
I COMPONENT NO: I TO 12/31/2009 I
I 14-3987 I I

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
1 POSITIONS				
2 PHYSICIANS	4.47	42,558	4,200	18,774
3 PHYSICIAN ASSISTANTS			2,100	
4 NURSE PRACTITIONERS	1.20	2,691	2,100	2,520
5 SUBTOTAL (SUM OF LINES 1-3)	5.67	45,249		21,294
6 VISITING NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 TOTAL FTES AND VISITS (SUM OF LINES 4-7)	5.67	45,249		
10 PHYSICIAN SERVICES UNDER AGREEMENTS				
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10 TOTAL COSTS OF HEALTH CARE SERVICES	2,458,049			
(FROM WORKSHEET M-1, COLUMN 7, LINE 22)				
11 TOTAL NONREIMBURSABLE COSTS	257,340			
(FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)	2,715,389			
(SUM OF LINES 10 AND 11)				
13 RATIO OF RHC/FQHC SERVICES	.905229			
(LINE 10 DIVIDED BY LINE 12)				
14 TOTAL FACILITY OVERHEAD	805,882			
(FROM WORKSHEET M-1, COLUMN 7, LINE 31)				
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	2,492,789			
(SEE INSTRUCTIONS)				
16 TOTAL OVERHEAD	3,298,671			
(SUM OF LINES 14 AND 15)				
17 ALLOWABLE GME OVERHEAD				
(SEE INSTRUCTIONS)				
18 SUBTRACT LINE 17 FROM LINE 16	3,298,671			
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	2,986,053			
(LINE 13 X LINE 18)				
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	5,444,102			
(SUM OF LINES 10 AND 19)				
		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)	45,249			
6 VISITING NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 TOTAL FTES AND VISITS (SUM OF LINES 4-7)	45,249			
10 PHYSICIAN SERVICES UNDER AGREEMENTS				

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

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-2
I COMPONENT NO: I TO 12/31/2009 I
I 14-3989 I I

RHC 2

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1 PHYSICIANS	.01		4,200	42
2 PHYSICIAN ASSISTANTS			2,100	
3 NURSE PRACTITIONERS	.84	2,237	2,100	1,764
4 SUBTOTAL (SUM OF LINES 1-3)	.85	2,237		1,806
5 VISITING NURSE				
6 CLINICAL PSYCHOLOGIST				
7 CLINICAL SOCIAL WORKER				
8 TOTAL FTES AND VISITS (SUM OF LINES 4-7)	.85	2,237		
9 PHYSICIAN SERVICES UNDER AGREEMENTS				
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10 TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	152,109			
11 TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	24,695			
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	176,804			
13 RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	.860326			
14 TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	65,490			
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	183,573			
16 TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	249,063			
17 ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18 SUBTRACT LINE 17 FROM LINE 16	249,063			
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	214,275			
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	366,384			
	GREATER OF COL. 2 OR COL. 4 5			
POSITIONS				
1 PHYSICIANS				
2 PHYSICIAN ASSISTANTS				
3 NURSE PRACTITIONERS				
4 SUBTOTAL (SUM OF LINES 1-3)	2,237			
5 VISITING NURSE				
6 CLINICAL PSYCHOLOGIST				
7 CLINICAL SOCIAL WORKER				
8 TOTAL FTES AND VISITS (SUM OF LINES 4-7)	2,237			
9 PHYSICIAN SERVICES UNDER AGREEMENTS				

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

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-2
I COMPONENT NO: I TO 12/31/2009 I
I 14-3431 I I

RHC 3

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS	.01	15	4,200
2	PHYSICIAN ASSISTANTS			2,100
3	NURSE PRACTITIONERS	.53	984	2,100
4	SUBTOTAL (SUM OF LINES 1-3)	.54	999	1,113
5	VISITING NURSE			1,155
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	.54	999	
9	PHYSICIAN SERVICES UNDER AGREEMENTS			
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	85,094		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	7,957		
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	93,051		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	.914488		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	34,533		
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	95,478		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	130,011		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	130,011		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	118,893		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	203,987		
		GREATER OF COL. 2 OR COL. 4 5		
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	1,155		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	1,155		
9	PHYSICIAN SERVICES UNDER AGREEMENTS			

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

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES		
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	5,444,102	
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	26,803	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	5,417,299	
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	45,249	
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)		
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	45,249	
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	119.72	
			CALCULATION OF LIMIT (1)
		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)		999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	119.72	119.72
10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		9,540
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		1,142,129
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		1,142,129
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		111,246
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		1,030,883
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		824,706
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		14,861
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		839,567
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		59,294
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)		898,861
25	INTERIM PAYMENTS		777,499
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		121,362
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 2

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES	UCATION PASS THROUGH COST.	
1 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	366,384	
2 COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	1,488	
3 TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	364,896	
4 TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	2,237	
5 PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)		
6 TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,237	
7 ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	163.12	
	CALCULATION OF LIMIT (1)	
	PRIOR TO	ON OR AFTER
	JANUARY 1	JANUARY 1
	1	2
8 PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)		999.00
9 RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	163.12	163.12
CALCULATION OF SETTLEMENT		
10 PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		355
11 PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		57,908
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)*		57,908
16.01 PRIMARY PAYER AMOUNT		
17 LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		4,759
18 NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		53,149
19 REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		42,519
20 PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		884
21 TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		43,403
22 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		2,101
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)		45,504
25 INTERIM PAYMENTS		35,029
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		10,475
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

TITLE XVIII RHC 3

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES	UCATION PASS THROUGH COST.	
1 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	203,987	
2 COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	1,039	
3 TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	202,948	
4 TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	1,155	
5 PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)		
6 TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	1,155	
7 ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	175.71	
		CALCULATION OF LIMIT (1)
	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8 PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)		999.00
9 RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	175.71	175.71
10 CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		119
11 PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		20,909
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)*		20,909
16.01 PRIMARY PAYER AMOUNT		
17 LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		1,749
18 NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		19,160
19 REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		15,328
20 PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		452
21 TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		15,780
22 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		1,053
22.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23 OTHER ADJUSTMENTS (SPECIFY)		
24 NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		16,833
25 INTERIM PAYMENTS		13,815
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		3,018
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-4
 I COMPONENT NO: I TO 12/31/2009 I
 I 14-3987 I I

TITLE XVIII

RHC 1

	PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	2,354,852	2,354,852	2,354,852	2,354,852
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000067	.001823		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	158	4,293		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	2,701	4,293		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	2,859	8,586		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	2,458,049	2,458,049	2,458,049	2,458,049
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	3,298,671	3,298,671	3,298,671	3,298,671
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.001163	.003493		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	3,836	11,522		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	6,695	20,108		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	73	428		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	91.71	46.98		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	35	248		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	3,210	11,651		
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)		26,803		
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)		14,861		

COMPUTATION OF PNEUMOCOCCAL AND
INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-4
 I COMPONENT NO: I TO 12/31/2009 I
 I 14-3989 I I

TITLE XVIII

RHC 2

	PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	151,518	151,518	151,518	151,518
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000049	.000452		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	7	68		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	37	452		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	44	520		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	152,109	152,109	152,109	152,109
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	249,063	249,063	249,063	249,063
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000289	.003419		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	72	852		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	116	1,372		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	1	45		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	116.00	30.49		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		29		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)		884		
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)		1,488		
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)		884		

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-4
 I COMPONENT NO: I TO 12/31/2009 I
 I 14-3431 I I

TITLE XVIII

RHC 3

	PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	84,496	84,496	84,496	84,496
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000025	.001137		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	2	96		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	111	202		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	113	298		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	85,094	85,094	85,094	85,094
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	130,011	130,011	130,011	130,011
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.001328	.003502		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	173	455		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	286	753		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	3	20		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	95.33	37.65		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		12		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)		452		
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)		1,039		
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)		452		

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

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-5
 I COMPONENT NO: I TO 12/31/2009 I
 I 14-3987 I I

RHC 1

DESCRIPTION	P A R T		B AMOUNT
	MM/DD/YYYY		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1		777,499
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
ADJUSTMENTS TO PROVIDER		.01	
ADJUSTMENTS TO PROVIDER		.02	
ADJUSTMENTS TO PROVIDER		.03	
ADJUSTMENTS TO PROVIDER		.04	
ADJUSTMENTS TO PROVIDER		.05	
ADJUSTMENTS TO PROGRAM		.50	
ADJUSTMENTS TO PROGRAM		.51	
ADJUSTMENTS TO PROGRAM		.52	
ADJUSTMENTS TO PROGRAM		.53	
ADJUSTMENTS TO PROGRAM		.54	
ADJUSTMENTS TO PROGRAM		.99	
SUBTOTAL			NONE
4 TOTAL INTERIM PAYMENTS			777,499
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		.01	121,362
AMOUNT (BALANCE DUE)		.02	
BASED ON COST REPORT (1)			
7 TOTAL MEDICARE PROGRAM LIABILITY			898,861

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

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

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2010
 I 14-1320 I FROM 1/ 1/2009 I WORKSHEET M-5
 I COMPONENT NO: I TO 12/31/2009 I
 I 14-3989 I I

RHC 2

DESCRIPTION	P A R T		B AMOUNT
	MM/DD/YYYY		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1		2 35,029
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
ADJUSTMENTS TO PROVIDER .01			
ADJUSTMENTS TO PROVIDER .02			
ADJUSTMENTS TO PROVIDER .03			
ADJUSTMENTS TO PROVIDER .04			
ADJUSTMENTS TO PROVIDER .05			
ADJUSTMENTS TO PROGRAM .50			
ADJUSTMENTS TO PROGRAM .51			
ADJUSTMENTS TO PROGRAM .52			
ADJUSTMENTS TO PROGRAM .53			
ADJUSTMENTS TO PROGRAM .54			
ADJUSTMENTS TO PROGRAM .99			
4 SUBTOTAL			NONE
4 TOTAL INTERIM PAYMENTS			35,029
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 SUBTOTAL			NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			10,475
7 SETTLEMENT TO PROVIDER .01			
7 SETTLEMENT TO PROGRAM .02			
7 TOTAL MEDICARE PROGRAM LIABILITY			45,504

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

RHC 3

DESCRIPTION	P A R T		B AMOUNT
	MM/DD/YYYY		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1	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.		2	13,815
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
ADJUSTMENTS TO PROVIDER			.01
ADJUSTMENTS TO PROVIDER			.02
ADJUSTMENTS TO PROVIDER			.03
ADJUSTMENTS TO PROVIDER			.04
ADJUSTMENTS TO PROVIDER			.05
ADJUSTMENTS TO PROGRAM			.50
ADJUSTMENTS TO PROGRAM			.51
ADJUSTMENTS TO PROGRAM			.52
ADJUSTMENTS TO PROGRAM			.53
ADJUSTMENTS TO PROGRAM			.54
ADJUSTMENTS TO PROGRAM			.99
SUBTOTAL			NONE
4 TOTAL INTERIM PAYMENTS			13,815
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)			3,018
7 TOTAL MEDICARE PROGRAM LIABILITY			16,833

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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