

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 5
 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	14-1321	I	FROM 7/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 6/30/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 12/ 8/2009 TIME 9:46

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
 FRANKLIN HOSPITAL 14-1321
 FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2008 AND ENDING 6/30/2009 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	252,155	479,804	0	0
3	SWING BED - SNF	0	33,820	0	0	0
5	HOSPITAL-BASED SNF	0	-7,333	0	0	0
9	RHC	0	0	-11,658	0	0
100	TOTAL	0	278,642	468,146	0	0

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET S-2
 I I TO 6/30/2009 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

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

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P, T, O OR N)		
					V	XVIII	XIX
02.00 HOSPITAL	FRANKLIN HOSPITAL	14-1321		8/ 1/2002	N	O	N
04.00 SWING BED - SNF	FRANKLIN HOSP SWING BED	14-2321		8/ 1/2002	N	O	N
06.00 HOSPITAL-BASED SNF	BENTON SNF	14-6088		8/12/2005	N	P	N
14.00 HOSPITAL-BASED RHC	FRANKLIN RHC	14-3469		7/ 6/2005	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2008 TO: 6/30/2009

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? N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 N Y
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO. N
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) 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.
- 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
- 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET S-2
 I I TO 6/30/2009 I

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

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

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

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 8/ 1/2002

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

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	100	0.8335	0.8386	
	855.00	2	14	99914

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

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

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

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

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

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

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 THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER. IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE N
 40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #
 40.02 STREET: P.O. BOX:
 40.03 CITY: STATE: ZIP CODE: -
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? 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
49.00 SNF	N	N			

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

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

	DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX
IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET S-2
I I TO 6/30/2009 I

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 REPORT FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? 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 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 INSTRUCTIONS) 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
62.01					0.00
62.02					0.00
62.03					0.00
62.04					0.00
62.05					0.00
62.06					0.00
62.07					0.00
62.08					0.00
62.09					0.00

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). / /

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET S-3
I I TO 6/30/2009 I PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	25	9,125	100.00			995	82
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						83	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	9,125	100.00			1,078	82
12 TOTAL	25	9,125	100.00			1,078	82
13 RPCH VISITS							
15 SKILLED NURSING FACILITY	83	30,295				661	1,786
24 RURAL HEALTH CLINIC						2,525	
25 TOTAL	108						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX OBSERVATION ADMITTED 5.01	I/P DAYS / OBSERVATION NOT ADMITTED 5.02	BEDS TOTAL 6	O/P VISITS ALL PATS 6	/ TRIPS TOTAL OBSERVATION ADMITTED 6.01	DISCHARGES / OBSERVATION NOT ADMITTED 6.02	INTERNS & RES. TOTAL 7	FTES -- LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS				1,099				
2 HMO								
2 01 HMO - (IRF PPS SUBPROVIDER)								
3 ADULTS & PED-SB SNF				83				
4 ADULTS & PED-SB NF								
5 TOTAL ADULTS AND PEDS				1,182				
12 TOTAL				1,182				
13 RPCH VISITS								
15 SKILLED NURSING FACILITY				3,358				
24 RURAL HEALTH CLINIC				9,636				
25 TOTAL								
26 OBSERVATION BED DAYS				247		247		
27 AMBULANCE TRIPS								
28 EMPLOYEE DISCOUNT DAYS								
28 01 EMP DISCOUNT DAYS -IRF								

COMPONENT	I & R FTES NET 9	FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					335	34	417
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
12 TOTAL		131.46			335	34	417
13 RPCH VISITS							
15 SKILLED NURSING FACILITY		1.00					
24 RURAL HEALTH CLINIC		11.09					
25 TOTAL		143.55					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

GROUP(1) 1	M3PI REVENUE CODE 2	SERVICES PRIOR TO RATE 3	10/1 DAYS 3.01	SERVICES RATE 4	ON/AFTER 10/1 DAYS 4.01	SRVCS 4/1/01 TO 9/30/01 RATE 4.02	DAYS 4.03
1	RUC		39				
2	RUB		131				
3	RUA		23				
3 .01	RUX		9				
3 .02	RUL		1				
4	RVC		31				
5	RVB		107				
6	RVA		61				
6 .01	RVX		8				
6 .02	RVL		14				
7	RHC		70				
8	RHB		13				
9	RHA		7				
9 .01	RHX						
9 .02	RHL						
10	RMC						
11	RMB						
12	RMA						
12 .01	RMX		40				
12 .02	RML		26				
13	RLB						
14	RLA						
14 .01	RLX						
15	SE3						
16	SE2		17				
17	SE1						
18	SSC						
19	SSB						
20	SSA						
21	CC2						
22	CC1						
23	CB2						
24	CB1						
25	CA2		1				
26	CA1		33				
27	IB2						
28	IB1						
29	IA2						
30	IA1						
31	BB2						
32	BB1						
33	BA2						
34	BA1						
35	PE2						
36	PE1						
37	PD2						
38	PD1						
39	PC2		30				
40	PC1						
41	PB2						
42	PB1						
43	PA2						
44	PA1						
45	Default						
46	TOTAL		661				

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

worksheet S-2 reference data:
 Transition Period : 100% Federal
 Wage Index Factor (before 10/01): 0.8335
 Wage Index Factor (after 10/01) : 0.8386
 SNF Facility Specific Rate : 855.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 14
 SNF CBSA Code : 99914

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET S-7
I I TO 6/30/2009 I

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

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

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

worksheet S-2 reference data:
 Transition Period : 100% Federal
 wage Index Factor (before 10/01): 0.8335
 wage Index Factor (after 10/01) : 0.8386
 SNF Facility Specific Rate : 855.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 14
 SNF CBSA Code : 99914

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET S-7
I I TO 6/30/2009 I NOT A CMS WORKSHEET
SERVICES THROUGH 12/31/2005

	GROUP(1)	M3PI REVENUE CODE	SERVICES	PRIOR TO	OCTOBER 1ST	SERVICES	ON OR AFTER	OCTOBER 1ST
			BASE RATE	RATE	DAYS	BASE RATE	RATE	DAYS
	1		3a	3	3.01	4a	4	4.01
1	RUC		478.65			497.80	497.80	39
2	RUB		442.78			460.49	460.49	131
3	RUA		424.23			441.19	441.19	23
3	.01 RUX		555.34			577.55	577.55	9
3	.02 RUL		493.49			513.24	513.24	1
4	RVC		378.00			393.12	393.12	31
5	RVB		360.68			375.12	375.12	107
6	RVA		327.29			340.39	340.39	61
6	.01 RVX		416.34			433.00	433.00	8
6	.02 RVL		390.37			405.99	405.99	14
7	RHC		323.91			336.86	336.86	70
8	RHB		310.31			322.72	322.72	13
9	RHA		289.28			300.84	300.84	7
9	.01 RHX		348.65			362.60		
9	.02 RHL		342.47			356.16		
10	RMC		296.13			307.99		
11	RMB		288.72			300.27		
12	RMA		282.53			293.84		
12	.01 RMX		392.62			408.32	408.32	40
12	.02 RML		361.69			376.16	376.16	26
13	RLB		256.66			266.93		
14	RLA		220.79			229.62		
14	.01 RLX		277.69			288.79		
15	SE3		311.09			323.53		
16	SE2		265.33			275.94	275.94	17
17	SE1		236.87			246.34		
18	SSC		233.17			242.48		
19	SSB		220.79			229.62		
20	SSA		217.09			225.77		
21	CC2		231.93			241.20		
22	CC1		212.13			220.62		
23	CB2		202.24			210.32		
24	CB1		193.58			201.32		
25	CA2		192.34			200.03	200.03	1
26	CA1		179.97			187.17	187.17	33
27	IB2		172.55			179.45		
28	IB1		170.08			176.88		
29	IA2		156.47			162.73		
30	IA1		150.28			156.29		
31	BB2		171.32			178.17		
32	BB1		166.37			173.02		
33	BA2		155.24			161.44		
34	BA1		145.34			151.15		
35	PE2		186.16			193.60		
36	PE1		182.45			189.75		
37	PD2		177.50			184.60		
38	PD1		175.03			182.03		
39	PC2		168.85			175.59	175.59	30
40	PC1		166.37			173.02		
41	PB2		149.05			155.01		
42	PB1		147.81			153.72		
43	PA2		146.57			152.43		
44	PA1		142.87			148.58		
45	Default		142.87			148.58		
46	TOTAL							661

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

Worksheet S-2 reference data:
 Transition Period : 100% Federal
 Wage Index Factor (before 10/01): 0.8335
 Wage Index Factor (after 10/01) : 0.8386
 SNF Facility Specific Rate : 855.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 14
 SNF CBSA Code : 99914

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

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET S-7
 I I TO 6/30/2009 I NOT A CMS WORKSHEET
 SERVICES THROUGH 12/31/2005

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

GROUP(1)	M3PI REVENUE CODE	A I D S		DIAGNOSIS		CODE 042		SWING BED SNF	TOTAL
		SERV PRIOR	TO OCT. 1ST	SERV ON/AFTER	OCT. 1ST	RATE	DAYS		
1	2	4.02	4.03	4.04	4.05	4.06			
1	RUC	1,091.32		1,134.98				19,414	
2	RUB	1,009.54		1,049.92				60,324	
3	RUA	967.24		1,005.91				10,147	
3 .01	RUX	1,266.18		1,316.81				5,198	
3 .02	RUL	1,125.16		1,170.19				513	
4	RVC	861.84		896.31				12,187	
5	RVB	822.35		855.27				40,138	
6	RVA	746.22		776.09				20,764	
6 .01	RVX	949.26		987.24				3,464	
6 .02	RVL	890.04		925.66				5,684	
7	RHC	738.51		768.04				23,580	
8	RHB	707.51		735.80				4,195	
9	RHA	659.56		685.92				2,106	
9 .01	RHX	794.92		826.73					
9 .02	RHL	780.83		812.04					
10	RMC	675.18		702.22					
11	RMB	658.28		684.62					
12	RMA	644.17		669.96					
12 .01	RMX	895.17		930.97				16,333	
12 .02	RML	824.65		857.64				9,780	
13	RLB	585.18		608.60					
14	RLA	503.40		523.53					
14 .01	RLX	633.13		658.44					
15	SE3	709.29		737.65					
16	SE2	604.95		629.14				4,691	
17	SE1	540.06		561.66					
18	SSC	531.63		552.85					
19	SSB	503.40		523.53					
20	SSA	494.97		514.76					
21	CC2	528.80		549.94					
22	CC1	483.66		503.01					
23	CB2	461.11		479.53					
24	CB1	441.36		459.01					
25	CA2	438.54		456.07				200	
26	CA1	410.33		426.75				6,177	
27	IB2	393.41		409.15					
28	IB1	387.78		403.29					
29	IA2	356.75		371.02					
30	IA1	342.64		356.34					
31	BB2	390.61		406.23					
32	BB1	379.32		394.49					
33	BA2	353.95		368.08					
34	BA1	331.38		344.62					
35	PE2	424.44		441.41					
36	PE1	415.99		432.63					
37	PD2	404.70		420.89					
38	PD1	399.07		415.03					
39	PC2	384.98		400.35				5,268	
40	PC1	379.32		394.49					
41	PB2	339.83		353.42					
42	PB1	337.01		350.48					
43	PA2	334.18		347.54					
44	PA1	325.74		338.76					
45	Default	325.74		338.76					
46	TOTAL							250,163	

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

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

worksheet S-2 reference data:

Transition Period : 100% Federal
 Wage Index Factor (before 10/01): 0.8335
 Wage Index Factor (after 10/01) : 0.8386
 SNF Facility Specific Rate : 855.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 14
 SNF CBSA Code : 99914

Non-CMS S-7 options selected:

[x] Calculate Total Days from this worksheet.
 [x] Transfer total to settlement worksheet.

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

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET S-8
I COMPONENT NO: I TO 6/30/2009 I
I 14-3469 I

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 201 BAILEY LANE
1.01 CITY: BENTON STATE: IL ZIP CODE: 62812 COUNTY: FRANKLIN
2 DESIGNATION (FOR 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 DR RESABA	
	PHYSICIAN NAME	HOURS OF SUPERVISION

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
12 CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14
	900	2200	900	2200	900	2200	900	2200	900	2200	900	2200	900	2200

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

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

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CDNSOLIDATED GROUP. IF ND, 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.

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET A
I I TO 6/30/2009 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		371,055	371,055		371,055
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		378,446	378,446	25,018	403,464
5	0500 EMPLOYEE BENEFITS	47,445	1,176,365	1,223,810		1,223,810
6	0600 ADMINISTRATIVE & GENERAL	848,243	1,162,223	2,010,466	357,619	2,368,085
7	0700 MAINTENANCE & REPAIRS	213,460	185,418	398,878		398,878
8	0800 OPERATION OF PLANT		465,276	465,276		465,276
9	0900 LAUNDRY & LINEN SERVICE		64,797	64,797		64,797
10	1000 HOUSEKEEPING	162,713	17,902	180,615		180,615
11	1100 DIETARY	368,344	329,568	697,912	-133,944	563,968
12	1200 CAFETERIA				133,944	133,944
14	1400 NURSING ADMINISTRATION	381,527	21,616	403,143		403,143
17	1700 MEDICAL RECORDS & LIBRARY	150,339	36,426	186,765		186,765
18	1800 SOCIAL SERVICE					
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	699,810	32,521	732,331	-23,977	708,354
34	3400 SKILLED NURSING FACILITY	240,661	255,947	496,608		496,608
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	169,723	106,124	275,847	-55,061	220,786
40	4000 ANESTHESIOLOGY		59,319	59,319	-4,351	54,968
41	4100 RADIOLOGY-DIAGNOSTIC	439,775	171,353	611,128	-27,904	583,224
44	4400 LABORATORY	327,525	517,877	845,402	-286,470	558,932
49	4900 RESPIRATORY THERAPY	240,406	105,701	346,107	-21,681	324,426
50	5000 PHYSICAL THERAPY	22,863	209,559	232,422	-1,549	230,873
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	67,328	46,672	114,000	474,057	588,057
56	5600 DRUGS CHARGED TO PATIENTS	142,541	315,695	458,236	-1,550	456,686
59	3020 SNF PT		1	1		1
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	189,077	174,042	363,119		363,119
61	6100 EMERGENCY	557,633	1,400,694	1,958,327	-46,989	1,911,338
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	684,753	37,384	722,137	-4,480	717,657
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		382,637	382,637	-382,637	
95	SUBTOTALS	5,954,166	8,024,618	13,978,784	45	13,978,829
	NONREIMBURS COST CENTERS					
100	7954 OTHER NONREIMBURSABLE COST CENTERS					
100.01	7951 UNASSIGNED SPACE					
100.02	7952 LEASED CLINICS		32,097	32,097	-45	32,052
100.03	7953 MARKETING	54,019	39,670	93,689		93,689
101	TOTAL	6,008,185	8,096,385	14,104,570	-0-	14,104,570

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET A
I I TO 6/30/2009 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT		371,055
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		403,464
5	0500 EMPLOYEE BENEFITS		1,223,810
6	0600 ADMINISTRATIVE & GENERAL	-22,659	2,345,426
7	0700 MAINTENANCE & REPAIRS		398,878
8	0800 OPERATION OF PLANT	-126,742	338,534
9	0900 LAUNDRY & LINEN SERVICE		64,797
10	1000 HOUSEKEEPING		180,615
11	1100 DIETARY	-243,118	320,850
12	1200 CAFETERIA	-80,984	52,960
14	1400 NURSING ADMINISTRATION		403,143
17	1700 MEDICAL RECORDS & LIBRARY		186,765
18	1800 SOCIAL SERVICE		
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		708,354
34	3400 SKILLED NURSING FACILITY		496,608
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-12,000	208,786
40	4000 ANESTHESIOLOGY	-49,077	5,891
41	4100 RADIOLOGY-DIAGNOSTIC		583,224
44	4400 LABORATORY	-25,118	533,814
49	4900 RESPIRATORY THERAPY	-43,200	281,226
50	5000 PHYSICAL THERAPY		230,873
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		588,057
56	5600 DRUGS CHARGED TO PATIENTS	-4,258	452,428
59	3020 SNF PT		1
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		363,119
61	6100 EMERGENCY	-837,186	1,074,152
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC		717,657
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
95	SUBTOTALS	-1,444,342	12,534,487
	NONREIMBURS COST CENTERS		
100	7954 OTHER NONREIMBURSABLE COST CENTERS		
100.01	7951 UNASSIGNED SPACE		
100.02	7952 LEASED CLINICS		32,052
100.03	7953 MARKETING		93,689
101	TOTAL	-1,444,342	12,660,228

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 6/30/2009 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	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
34	SKILLED NURSING FACILITY	3400	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	SNF PT	3020	ACUPUNCTURE
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
100	OTHER NONREIMBURSABLE COST CENTERS	7954	OTHER NONREIMBURSABLE COST CENTERS
100.01	UNASSIGNED SPACE	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	LEASED CLINICS	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	MARKETING	7953	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
141321	FROM 7/ 1/2008	WORKSHEET A-6
	TO 6/30/2009	

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 CAFETERIA					
2 SUPPLIES	A	CAFETERIA	12	70,693	63,251
3	B	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		474,057
4					
5					
6					
7					
8					
9					
10					
11					
12					
13 INTEREST	C	NEW CAP REL COSTS-MVBLE EQUIP	4		25,018
14		ADMINISTRATIVE & GENERAL	6		357,619
36 TOTAL RECLASSIFICATIONS				70,693	919,945

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 12/ 8/2009
141321	FROM 7/ 1/2008	WORKSHEET A-6
	TO 6/30/2009	

EXPLANATION OF RECLASSIFICATION	DECREASE				A-7 REF 10	
	CODE (1)	COST CENTER 6	LINE NO 7	SALARY 8		OTHER 9
1 CAFETERIA	A	DIETARY	11	70,693	63,251	
2 SUPPLIES	B	ADULTS & PEDIATRICS	25		23,977	
3		OPERATING ROOM	37		55,061	
4		ANESTHESIOLOGY	40		4,351	
5		RADIOLOGY-DIAGNOSTIC	41		27,904	
6		LABORATORY	44		286,470	
7		RESPIRATORY THERAPY	49		21,681	
8		PHYSICAL THERAPY	50		1,549	
9		DRUGS CHARGED TO PATIENTS	56		1,550	
10		EMERGENCY	61		46,989	
11		RURAL HEALTH CLINIC	63.50		4,480	
12		LEASED CLINICS	100.02		45	
13 INTEREST	C	INTEREST EXPENSE	88		382,637	11
14						
36 TOTAL RECLASSIFICATIONS				70,693	919,945	

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

RECLASSIFICATIONS

RECLASS CODE: A
 EXPLANATION : CAFETERIA

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	CAFETERIA	12	133,944	DIETARY	11	133,944	
TOTAL RECLASSIFICATIONS FOR CODE A			133,944				

RECLASS CODE: B
 EXPLANATION : SUPPLIES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	474,057	ADULTS & PEDIATRICS	25	23,977	
2.00			0	OPERATING ROOM	37	55,061	
3.00			0	ANESTHESIOLOGY	40	4,351	
4.00			0	RADIOLOGY-DIAGNOSTIC	41	27,904	
5.00			0	LABORATORY	44	286,470	
6.00			0	RESPIRATORY THERAPY	49	21,681	
7.00			0	PHYSICAL THERAPY	50	1,549	
8.00			0	DRUGS CHARGED TO PATIENTS	56	1,550	
9.00			0	EMERGENCY	61	46,989	
10.00			0	RURAL HEALTH CLINIC	63.50	4,480	
11.00			0	LEASED CLINICS	100.02	45	
TOTAL RECLASSIFICATIONS FOR CODE B			474,057	474,057			

RECLASS CODE: C
 EXPLANATION : INTEREST

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	25,018	INTEREST EXPENSE	88	382,637	
2.00	ADMINISTRATIVE & GENERAL	6	357,619			0	
TOTAL RECLASSIFICATIONS FOR CODE C			382,637	382,637			

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
			PURCHASES 2	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	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
			PURCHASES 2	DONATION 3				
1	LAND	18,401					18,401	
2	LAND IMPROVEMENTS	128,355				24,576	103,779	
3	BUILDINGS & FIXTURE	11,908,761				1,355,129	10,553,632	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	4,313,417	149,217		149,217		4,462,634	
7	SUBTOTAL	16,368,934	149,217		149,217	1,379,705	15,138,446	
8	RECONCILING ITEMS							
9	TOTAL	16,368,934	149,217		149,217	1,379,705	15,138,446	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	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	
3	NEW CAP REL COSTS-BL	10,675,812		10,675,812	.705212			
4	NEW CAP REL COSTS-MV	4,462,634		4,462,634	.294788			
5	TOTAL	15,138,446		15,138,446	1.000000			

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	371,055						371,055
4	NEW CAP REL COSTS-MV	378,446		25,018				403,464
5	TOTAL	749,501		25,018				774,519

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	371,055						371,055
4	NEW CAP REL COSTS-MV	378,446						378,446
5	TOTAL	749,501						749,501

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET A-8
 I I TO 6/30/2009 I

IN LIEU OF FORM CMS-2552-96(05/1999)

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION DN	LINE NO	WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER		
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	11
5 INVESTMENT INCOME-OTHER	B	-3,944	ADMINISTRATIVE & GENERAL	6	
6 TRADE, QUANTITY AND TIME DISCOUNTS	B	-174	ADMINISTRATIVE & GENERAL	6	
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-966,580			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-80,984	CAFETERIA	12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS	B	-13,000	OPERATION OF PLANT	8	
18 SALE OF MED AND SURG SUPPLIES					
19 SALE DF DRUGS TD DOTHER THAN PATIENTS	B	-4,258	DRUGS CHARGED TO PATIENTS	56	
20 SALE OF MEDICAL RECORDS & ABSTRACTS					
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP					
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	89	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	1	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	2	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-BLDG &	3	
33 NON-PHYSICIAN ANESTHETIST			NEW CAP REL COSTS-MVBLE E	4	
34 PHYSICIANS' ASSISTANT			**COST CENTER DELETED**	20	
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37 DIETARY	B	-300	DIETARY	11	
38 MISCELLANEOUS INCOME	B	-9,288	ADMINISTRATIVE & GENERAL	6	
39 ADVERTISING	B	-4,559	ADMINISTRATIVE & GENERAL	6	
40 LAB REVENUE	B	-1	LABORATORY	44	
41 NON CAH MISCELLANEOUS INCOME	B	-4,694	ADMINISTRATIVE & GENERAL	6	
42 BENTON DIETARY	B	-242,818	DIETARY	11	
43 BENTON UTILITIES	A	-113,742	OPERATION OF PLANT	8	
44					
45					
46					
47					
48					
49 OTHER ADJUSTMENTS (SPECIFY)					
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,444,342			

(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

IN LIEU OF FORM CMS-2552-96(9/1996)
 I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET A-8-2
 I I TO 6/30/2009 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 37	OR	12,000	12,000					
2 40	ANESTHESIA	49,077	49,077					
3 44	LAB	25,117	25,117					
4 49	RT	43,200	43,200					
5 61	ER	1,154,755	837,186	317,569				
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,284,149	966,580	317,569				

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

I PROVIDER NO: I 14-1321
 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009
 I PREPARED 12/ 8/2009 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	187
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	68
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

9	TOTAL HOURS WORKED		1394.00	1790.00	
10	AHSEA (SEE INSTRUCTIONS)		57.85	57.85	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	28.93	28.93	28.93	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	80,643
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	103,552
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	184,195
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	184,195

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	184,195

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	5,410
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	1,967
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	7,377
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	880
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	8,257
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

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

I PROVIDER NO: I 14-1321
 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009
 I PREPARED 12/ 8/2009 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 8,257
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 184,195
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 8,257
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

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

I PROVIDER NO: I 14-1321
 I PERIOD: I FROM 7/ 1/2008 I TO 6/30/2009
 I PREPARED 12/ 8/2009 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 192,452
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 145,252
 65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

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

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 6/30/2009 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	4	DOLLAR VALUE	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	1	SQUARE FEET	ENTERED
8	OPERATION OF PLANT	2	SQ FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF SERVICE	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	11	FTES	ENTERED
14	NURSING ADMINISTRATION	13	NRSNG FTES	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	GROSS REV	ENTERED
18	SOCIAL SERVICE	17	TIME SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	EMPLOYEE BENE FITS 5	SUBTOTAL 5a.00	ADMINISTRATIV E & GENERAL 6	MAINTENANCE & REPAIRS 7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	371,055	371,055					
005 NEW CAP REL COSTS-MVBLE E	403,464		403,464				
006 EMPLOYEE BENEFITS	1,223,810	1,084		1,224,894			
007 ADMINISTRATIVE & GENERAL	2,345,426	40,216	40,991	181,643	2,608,276	2,608,276	
008 MAINTENANCE & REPAIRS	398,878	15,629	89,594	45,710	549,811	150,079	699,890
009 OPERATION OF PLANT	338,534	49,307	136		387,977	105,904	137,965
010 LAUNDRY & LINEN SERVICE	64,797	4,295	100		69,192	18,887	12,016
011 HOUSEKEEPING	180,615	1,445		34,843	216,903	59,207	4,042
012 DIETARY	320,850	28,402	9,408	63,739	422,399	115,300	79,464
014 CAFETERIA	52,960			15,138	68,098	18,588	
017 NURSING ADMINISTRATION	403,143	2,154	116	81,700	487,113	132,965	6,026
018 MEDICAL RECORDS & LIBRARY	186,765	6,022	14,007	32,193	238,987	65,235	16,848
018 SOCIAL SERVICE		2,279			2,279	622	6,375
025 INPAT ROUTINE SRVC CNTRS							
034 ADULTS & PEDIATRICS	708,354	34,391	24,794	149,857	917,396	250,417	96,220
034 SKILLED NURSING FACILITY	496,608				496,608		
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	208,786	36,880	68,431	36,344	350,441	95,658	103,184
041 ANESTHESIOLOGY	5,891	591	487		6,969	1,902	1,654
044 RADIOLOGY-DIAGNOSTIC	583,224	15,813	117,083	94,173	810,293	221,182	44,243
049 LABORATORY	533,814	8,498	11,445	70,136	623,893	170,301	23,775
050 RESPIRATORY THERAPY	281,226	8,524	4,041	51,480	345,271	94,247	27,872
055 PHYSICAL THERAPY	230,873	8,852	1,657	4,896	246,278	67,225	24,767
056 MEDICAL SUPPLIES CHARGED	588,057	14,500	2,010	14,418	618,985	168,961	40,568
059 DRUGS CHARGED TO PATIENTS	452,428	6,107	6,502	30,524	495,561	135,271	17,087
059 SNF PT	1				1		
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC	363,119	7,480		40,489	411,088	112,213	20,927
062 EMERGENCY	1,074,152	14,611	706	119,411	1,208,880	329,985	36,857
063 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	717,657	24,278	11,956	146,632	900,523	245,811	
063 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	12,534,487	331,358	403,464	1,213,326	12,483,222	2,559,960	699,890
100 NONREIMBURS COST CENTERS							
100 01 OTHER NONREIMBURSABLE COS							
100 01 UNASSIGNED SPACE		709			709	194	
100 02 LEASED CLINICS	32,052	38,988			71,040	19,391	
100 03 MARKETING	93,689			11,568	105,257	28,731	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	12,660,228	371,055	403,464	1,224,894	12,660,228	2,608,276	699,890

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET B
 I I TO 6/30/2009 I PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
	8	9	10	11	12	14	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT	631,846						
009 LAUNDRY & LINEN SERVICE	12,054	112,149					
010 HOUSEKEEPING	4,055		284,207				
011 DIETARY	79,716			696,879			
012 CAFETERIA			10,179		96,865		
014 NURSING ADMINISTRATION	6,045				4,516	636,665	
017 MEDICAL RECORDS & LIBRARY	16,902		10,840		4,784		353,596
018 SOCIAL SERVICE	6,396						
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	96,525	48,565	67,019	696,879	19,906	258,823	19,059
034 SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	103,512	20,832	43,622		3,856	50,137	12,984
040 ANESTHESIOLOGY	1,659						1,211
041 RADIOLOGY-DIAGNOSTIC	44,383	19,896	15,070		11,211		91,665
044 LABORATORY	23,850		15,731		10,395		84,253
049 RESPIRATORY THERAPY	27,960	425	21,811		6,036		31,534
050 PHYSICAL THERAPY	24,845	5,855	8,724		11		4,285
055 MEDICAL SUPPLIES CHARGED	40,696				2,303		3,777
056 DRUGS CHARGED TO PATIENTS	17,141		2,908		2,772		25,955
059 SNF PT							
060 OUTPAT SERVICE COST CNTRS CLINIC	20,993	474			4,762		17,124
061 EMERGENCY	36,973	16,102	39,657		12,810	166,541	61,749
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	68,141		48,646		12,396	161,164	
095 SPEC PURPOSE COST CENTERS SUBTOTALS	631,846	112,149	284,207	696,879	95,758	636,665	353,596
100 NONREIMBURS COST CENTERS OTHER NONREIMBURSABLE COS							
100 01 UNASSIGNED SPACE							
100 02 LEASED CLINICS							
100 03 MARKETING					1,107		
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	631,846	112,149	284,207	696,879	96,865	636,665	353,596

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET B
 I I TO 6/30/2009 I PART I

COST CENTER DESCRIPTION	SOCIAL SERVIC SUBTOTAL E	I&R COST POST STEP-DOWN ADJ	TOTAL
	18	25	27
003 GENERAL SERVICE COST CNTR			
004 NEW CAP REL COSTS-BLDG &			
005 NEW CAP REL COSTS-MVBLE E			
006 EMPLOYEE BENEFITS			
007 ADMINISTRATIVE & GENERAL			
008 MAINTENANCE & REPAIRS			
009 OPERATION OF PLANT			
010 LAUNDRY & LINEN SERVICE			
011 HOUSEKEEPING			
012 DIETARY			
014 CAFETERIA			
017 NURSING ADMINISTRATION			
018 MEDICAL RECORDS & LIBRARY			
SOCIAL SERVICE	15,672		
025 INPAT ROUTINE SRVC CNTRS			
ADULTS & PEDIATRICS	15,672	2,486,481	2,486,481
034 SKILLED NURSING FACILITY		496,608	496,608
ANCILLARY SRVC COST CNTRS			
037 OPERATING ROOM		784,226	784,226
040 ANESTHESIOLOGY		13,395	13,395
041 RADIOLOGY-DIAGNOSTIC		1,257,943	1,257,943
044 LABORATORY		952,198	952,198
049 RESPIRATORY THERAPY		555,156	555,156
050 PHYSICAL THERAPY		381,990	381,990
055 MEDICAL SUPPLIES CHARGED		875,290	875,290
056 DRUGS CHARGED TO PATIENTS		696,695	696,695
059 SNF PT		1	1
060 OUTPAT SERVICE COST CNTRS			
CLINIC		587,581	587,581
061 EMERGENCY		1,909,554	1,909,554
062 OBSERVATION BEDS (NON-DIS			
063 OTHER OUTPATIENT SERVICE			
063 50 RURAL HEALTH CLINIC		1,436,681	1,436,681
SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	15,672	12,433,799	12,433,799
NONREIMBURS COST CENTERS			
100 OTHER NONREIMBURSABLE COS			
100 01 UNASSIGNED SPACE		903	903
100 02 LEASED CLINICS		90,431	90,431
100 03 MARKETING		135,095	135,095
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 TOTAL	15,672	12,660,228	12,660,228

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET B
 I I TO 6/30/2009 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	NEW CAP REL C OST-S-BLDG & 3	NEW CAP REL C OST-S-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	MAINTENANCE & REPAIRS 7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS		1,084		1,084	1,084		
006 ADMINISTRATIVE & GENERAL		40,216	40,991	81,207	158	81,365	
007 MAINTENANCE & REPAIRS		15,629	89,594	105,223	41	4,682	109,946
008 OPERATION OF PLANT		49,307	136	49,443		3,304	21,672
009 LAUNDRY & LINEN SERVICE		4,295	100	4,395		589	1,888
010 HOUSEKEEPING		1,445		1,445	31	1,847	635
011 DIETARY		28,402	9,408	37,810	57	3,597	12,483
012 CAFETERIA					13	580	
014 NURSING ADMINISTRATION		2,154	116	2,270	72	4,148	947
017 MEDICAL RECORDS & LIBRARY		6,022	14,007	20,029	29	2,035	2,647
018 SOCIAL SERVICE		2,279		2,279		19	1,002
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		34,391	24,794	59,185	133	7,812	15,115
034 SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		36,880	68,431	105,311	32	2,984	16,209
040 ANESTHESIOLOGY		591	487	1,078		59	260
041 RADIOLOGY-DIAGNOSTIC		15,813	117,083	132,896	84	6,900	6,950
044 LABORATORY		8,498	11,445	19,943	62	5,312	3,735
049 RESPIRATORY THERAPY		8,524	4,041	12,565	46	2,940	4,378
050 PHYSICAL THERAPY		8,852	1,657	10,509	4	2,097	3,891
055 MEDICAL SUPPLIES CHARGED		14,500	2,010	16,510	13	5,271	6,373
056 DRUGS CHARGED TO PATIENTS		6,107	6,502	12,609	27	4,220	2,684
059 SNF PT							
060 OUTPAT SERVICE COST CNTRS CLINIC		7,480		7,480	36	3,500	3,287
061 EMERGENCY		14,611	706	15,317	106	10,294	5,790
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC		24,278	11,956	36,234	130	7,668	
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		331,358	403,464	734,822	1,074	79,858	109,946
100 NONREIMBURS COST CENTERS							
100 01 OTHER NONREIMBURSABLE COS							
100 01 UNASSIGNED SPACE		709		709		6	
100 02 LEASED CLINICS		38,988		38,988		605	
100 03 MARKETING					10	896	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		371,055	403,464	774,519	1,084	81,365	109,946

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
	8	9	10	11	12	14	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	74,419						
010 LAUNDRY & LINEN SERVICE	1,420	8,292					
011 HOUSEKEEPING	478		4,436				
012 DIETARY	9,389			63,336			
014 CAFETERIA			159		752		
017 NURSING ADMINISTRATION	712				35	8,184	
018 MEDICAL RECORDS & LIBRARY	1,991		169		37		26,937
025 SOCIAL SERVICE	753						
034 INPAT ROUTINE SRVC CNTRS							
037 ADULTS & PEDIATRICS	11,369	3,591	1,047	63,336	154	3,327	1,452
040 SKILLED NURSING FACILITY							
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM	12,191	1,540	681		30	644	989
049 ANESTHESIOLOGY	195						92
050 RADIOLOGY-DIAGNOSTIC	5,227	1,471	235		87		6,979
055 LABORATORY	2,809		246		81		6,419
056 RESPIRATORY THERAPY	3,293	31	340		47		2,403
059 PHYSICAL THERAPY	2,926	433	136				327
060 MEDICAL SUPPLIES CHARGED	4,793				18		288
061 DRUGS CHARGED TO PATIENTS	2,019		45		22		1,978
062 SNF PT							
063 OUTPAT SERVICE COST CNTRS							
066 CLINIC	2,473	35			37		1,305
067 EMERGENCY	4,355	1,191	619		99	2,141	4,705
068 OBSERVATION BEDS (NON-DIS							
069 OTHER OUTPATIENT SERVICE							
070 RURAL HEALTH CLINIC	8,026		759		96	2,072	
071 SPEC PURPOSE COST CENTERS							
072 SUBTOTALS	74,419	8,292	4,436	63,336	743	8,184	26,937
073 NONREIMBURS COST CENTERS							
074 OTHER NONREIMBURSABLE COS							
075 01 UNASSIGNED SPACE							
076 02 LEASED CLINICS							
077 03 MARKETING					9		
078 CROSS FOOT ADJUSTMENTS							
079 NEGATIVE COST CENTER							
080 TOTAL	74,419	8,292	4,436	63,336	752	8,184	26,937

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET B
 I I TO 6/30/2009 I PART III

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	18	25	26	27
003 GENERAL SERVICE COST CNTR				
004 NEW CAP REL COSTS-BLDG &				
005 NEW CAP REL COSTS-MVBLE E				
006 EMPLOYEE BENEFITS				
007 ADMINISTRATIVE & GENERAL				
008 MAINTENANCE & REPAIRS				
009 OPERATION OF PLANT				
010 LAUNDRY & LINEN SERVICE				
011 HOUSEKEEPING				
012 DIETARY				
014 CAFETERIA				
017 NURSING ADMINISTRATION				
018 MEDICAL RECORDS & LIBRARY				
018 SOCIAL SERVICE	4,053			
025 INPAT ROUTINE SRVC CNTRS				
034 ADULTS & PEDIATRICS	4,053	170,574		170,574
037 SKILLED NURSING FACILITY				
037 ANCILLARY SRVC COST CNTRS				
040 OPERATING ROOM		140,611		140,611
041 ANESTHESIOLOGY		1,684		1,684
044 RADIOLOGY-DIAGNOSTIC		160,829		160,829
049 LABORATORY		38,607		38,607
050 RESPIRATORY THERAPY		26,043		26,043
055 PHYSICAL THERAPY		20,323		20,323
056 MEDICAL SUPPLIES CHARGED		33,266		33,266
059 DRUGS CHARGED TO PATIENTS		23,604		23,604
060 SNF PT				
060 OUTPAT SERVICE COST CNTRS				
061 CLINIC		18,153		18,153
062 EMERGENCY		44,617		44,617
063 OBSERVATION BEDS (NON-DIS				
063 OTHER OUTPATIENT SERVICE				
063 50 RURAL HEALTH CLINIC		54,985		54,985
095 SPEC PURPOSE COST CENTERS				
095 SUBTOTALS	4,053	733,296		733,296
100 NONREIMBURS COST CENTERS				
100 01 OTHER NONREIMBURSABLE COS				
100 01 UNASSIGNED SPACE		715		715
100 02 LEASED CLINICS		39,593		39,593
100 03 MARKETING		915		915
101 CROSS FOOT ADJUSTMENTS				
102 NEGATIVE COST CENTER				
103 TOTAL	4,053	774,519		774,519

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET B-1
 I I TO 6/30/2009 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	S RECONCILIATION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
	OSTS-BLDG & (SQUARE FEET)	OSTS-MVBLE E (DOLLAR VALUE)	FITS (GROSS SALARIES)		(ACCUM. COST)	(SQUARE FEET)
	3	4	5	6a.00	6	7
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	56,504					
005 NEW CAP REL COSTS-MVB		369,682				
006 EMPLOYEE BENEFITS	165		5,720,079			
007 ADMINISTRATIVE & GENE	6,124	37,559	848,243	-2,608,276	9,555,344	
008 MAINTENANCE & REPAIRS	2,380	82,092	213,460		549,811	38,093
009 OPERATION OF PLANT	7,509	125			387,977	7,509
010 LAUNDRY & LINEN SERVI	654	92			69,192	654
011 HOUSEKEEPING	220		162,713		216,903	220
012 DIETARY	4,325	8,620	297,651		422,399	4,325
014 CAFETERIA			70,693		68,098	
017 NURSING ADMINISTRATIO	328	106	381,527		487,113	328
018 MEDICAL RECORDS & LIB	917	12,834	150,339		238,987	917
025 SOCIAL SERVICE	347				2,279	347
034 INPAT ROUTINE SRVC CN						
037 ADULTS & PEDIATRICS	5,237	22,718	699,810		917,396	5,237
040 SKILLED NURSING FACIL				-496,608		
041 ANCILLARY SRVC COST C						
044 OPERATING ROOM	5,616	62,701	169,723		350,441	5,616
049 ANESTHESIOLOGY	90	446			6,969	90
050 RADIOLOGY-DIAGNOSTIC	2,408	107,279	439,775		810,293	2,408
055 LABORATORY	1,294	10,487	327,525		623,893	1,294
059 RESPIRATORY THERAPY	1,298	3,703	240,406		345,271	1,517
060 PHYSICAL THERAPY	1,348	1,518	22,863		246,278	1,348
061 MEDICAL SUPPLIES CHAR	2,208	1,842	67,328		618,985	2,208
062 DRUGS CHARGED TO PATI	930	5,958	142,541		495,561	930
063 SNF PT					1	
066 OUTPAT SERVICE COST C						
060 CLINIC	1,139		189,077		411,088	1,139
061 EMERGENCY	2,225	647	557,633		1,208,880	2,006
062 OBSERVATION BEDS (NON						
063 OTHER OUTPATIENT SERV						
063 50 RURAL HEALTH CLINIC	3,697	10,955	684,753		900,523	
095 SPEC PURPOSE COST CEN						
100 SUBTOTALS	50,459	369,682	5,666,060	-3,104,884	9,378,338	38,093
100 NONREIMBURS COST CENT						
100 01 OTHER NONREIMBURSABLE						
100 02 UNASSIGNED SPACE	108				709	
100 03 LEASED CLINICS	5,937				71,040	
101 03 MARKETING			54,019		105,257	
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	371,055	403,464	1,224,894		2,608,276	699,890
104 (WRKSHT B, PART I)						
105 UNIT COST MULTIPLIER	6.566880		.214139		.272965	
106 (WRKSHT B, PT I)		1.091381				18.373192
107 COST TO BE ALLDCATED						
108 (WRKSHT B, PART II)						
109 UNIT COST MULTIPLIER			1,084		81,365	109,946
110 (WRKSHT B, PART III)						
111 COST TO BE ALLOCATED			.000190		.008515	
112 UNIT COST MULTIPLIER						2.886252
113 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET B-1
 I I TO 6/30/2009 I

COST CENTER DESCRIPTION	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NRSNG FTES)	MEDICAL RECORDS & LIBRARY (GROSS REV)
	8	9	10	11	12	14	17
003 GENERAL SERVICE COST							
004 NEW CAP REL COSTS-BLD							
005 NEW CAP REL COSTS-MVB							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENE							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	34,281						
010 LAUNDRY & LINEN SERVI	654	27,198					
011 HOUSEKEEPING	220		2,150				
012 DIETARY	4,325			6,185			
013 CAFETERIA			77		8,666		
014 NURSING ADMINISTRATIO	328				404	4,381	
017 MEDICAL RECORDS & LIB	917		82		428		21,129,762
018 SOCIAL SERVICE	347						
025 INPAT ROUTINE SRVC CN							
034 ADULTS & PEDIATRICS	5,237	11,778	507	6,185	1,781	1,781	1,138,940
037 SKILLED NURSING FACIL							
040 ANCILLARY SRVC COST C							
041 OPERATING ROOM	5,616	5,052	330		345	345	775,877
044 ANESTHESIOLOGY	90						72,346
049 RADIOLOGY-DIAGNOSTIC	2,408	4,825	114		1,003		5,477,070
050 LABORATORY	1,294		119		930		5,034,867
055 RESPIRATORY THERAPY	1,517	103	165		540		1,884,422
059 PHYSICAL THERAPY	1,348	1,420	66		1		256,091
060 MEDICAL SUPPLIES CHAR	2,208				206		225,730
061 DRUGS CHARGED TO PATI	930		22		248		1,551,054
062 SNF PT							
063 OUTPAT SERVICE COST C							
063 50 CLINIC	1,139	115			426		1,023,307
063 01 EMERGENCY	2,006	3,905	300		1,146	1,146	3,690,058
063 02 OBSERVATION BEDS (NON							
063 03 OTHER OUTPATIENT SERV							
063 50 RURAL HEALTH CLINIC	3,697		368		1,109	1,109	
095 SPEC PURPOSE COST CEN							
095 SUBTOTALS	34,281	27,198	2,150	6,185	8,567	4,381	21,129,762
100 NONREIMBURS COST CENT							
100 01 OTHER NONREIMBURSABLE							
100 02 UNASSIGNED SPACE							
100 03 LEASED CLINICS							
101 03 MARKETING					99		
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	631,846	112,149	284,207	696,879	96,865	636,665	353,596
104 (WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER	18.431376	4.123428	132.189302	112.672433	11.177591	145.324127	.016734
105 (WRKSHT B, PT I)							
105 COST TO BE ALLOCATED							
106 (WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
107 (WRKSHT B, PT II)							
107 COST TO BE ALLOCATED	74,419	8,292	4,436	63,336	752	8,184	26,937
108 (WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER	2.170853	.304875	2.063256	10.240259	.086776	1.868067	.001275
108 (WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET B-1
 I I TO 6/30/2009 I

COST CENTER DESCRIPTION	SOCIAL SERVICE (TIME SPENT)
	18
003 GENERAL SERVICE COST	
004 NEW CAP REL COSTS-BLD	
005 NEW CAP REL COSTS-MVB	
006 EMPLOYEE BENEFITS	
007 ADMINISTRATIVE & GENE	
008 MAINTENANCE & REPAIRS	
009 OPERATION OF PLANT	
010 LAUNDRY & LINEN SERVI	
011 HOUSEKEEPING	
012 DIETARY	
012 CAFETERIA	
014 NURSING ADMINISTRATIO	
017 MEDICAL RECORDS & LIB	
018 SOCIAL SERVICE	100
025 INPAT ROUTINE SRVC CN	
034 ADULTS & PEDIATRICS	100
037 SKILLED NURSING FACIL	
040 ANCILLARY SRVC COST C	
041 OPERATING ROOM	
044 ANESTHESIOLOGY	
049 RADIOLOGY-DIAGNOSTIC	
050 LABORATORY	
055 RESPIRATORY THERAPY	
056 PHYSICAL THERAPY	
059 MEDICAL SUPPLIES CHAR	
060 DRUGS CHARGED TO PATI	
061 SNF PT	
062 OUTPAT SERVICE COST C	
063 CLINIC	
063 50 EMERGENCY	
063 01 OBSERVATION BEDS (NON	
063 02 OTHER OUTPATIENT SERV	
063 03 RURAL HEALTH CLINIC	
095 SPEC PURPOSE COST CEN	
100 SUBTOTALS	100
100 NONREIMBURS COST CENT	
100 01 OTHER NONREIMBURSABLE	
100 02 UNASSIGNED SPACE	
100 03 LEASED CLINICS	
101 03 MARKETING	
101 CROSS FOOT ADJUSTMENT	
102 NEGATIVE COST CENTER	
103 COST TO BE ALLOCATED	15,672
104 (PER WRKSHT B, PART	
104 UNIT COST MULTIPLIER	
105 (WRKSHT B, PT I)	156.720000
105 COST TO BE ALLOCATED	
106 (PER WRKSHT B, PART	
106 UNIT COST MULTIPLIER	
107 (WRKSHT B, PT II)	
107 COST TO BE ALLOCATED	4,053
108 (PER WRKSHT B, PART	
108 UNIT COST MULTIPLIER	
(WRKSHT B, PT III)	40.530000

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET C
 I I TO 6/30/2009 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	2,486,481		2,486,481		2,486,481
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS	496,608		496,608		496,608
37	OPERATING ROOM	784,226		784,226		784,226
40	ANESTHESIOLOGY	13,395		13,395		13,395
41	RADIOLOGY-DIAGNOSTIC	1,257,943		1,257,943		1,257,943
44	LABORATORY	952,198		952,198		952,198
49	RESPIRATORY THERAPY	555,156		555,156		555,156
50	PHYSICAL THERAPY	381,990		381,990		381,990
55	MEDICAL SUPPLIES CHARGED	875,290		875,290		875,290
56	DRUGS CHARGED TO PATIENTS	696,695		696,695		696,695
59	SNF PT	1		1		1
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	587,581		587,581		587,581
61	EMERGENCY	1,909,554		1,909,554		1,909,554
62	OBSERVATION BEDS (NON-DIS	429,782		429,782		429,782
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	1,436,681		1,436,681		1,436,681
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	12,863,581		12,863,581		12,863,581
102	LESS OBSERVATION BEDS	429,782		429,782		429,782
103	TOTAL	12,433,799		12,433,799		12,433,799

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	961,244		961,244			
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS	472,914		472,914			
37	OPERATING ROOM		775,877	775,877	1.010761	1.010761	1.010761
40	ANESTHESIOLOGY		23,255	23,255	.576005	.576005	.576005
41	RADIOLOGY-DIAGNOSTIC	308,049	5,169,022	5,477,071	.229674	.229674	.229674
44	LABORATORY	445,148	4,589,719	5,034,867	.189121	.189121	.189121
49	RESPIRATORY THERAPY	319,561	1,338,138	1,657,699	.334896	.334896	.334896
50	PHYSICAL THERAPY	32,555	223,536	256,091	1.491618	1.491618	1.491618
55	MEDICAL SUPPLIES CHARGED	187,060	265,393	452,453	1.934543	1.934543	1.934543
56	DRUGS CHARGED TO PATIENTS	526,334	1,024,719	1,551,053	.449175	.449175	.449175
59	SNF PT	93,547		93,547	.000011	.000011	.000011
60	OUTPAT SERVICE COST CNTRS CLINIC		1,023,307	1,023,307	.574198	.574198	.574198
61	EMERGENCY	38,355	3,651,703	3,690,058	.517486	.517486	.517486
62	OBSERVATION BEDS (NON-DIS		177,696	177,696	2.418636	2.418636	2.418636
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS		954,896	954,896	1.504542	1.504542	1.504542
101	SUBTOTAL	3,384,767	19,217,261	22,602,028			
102	LESS OBSERVATION BEDS						
103	TOTAL	3,384,767	19,217,261	22,602,028			

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,486,481		2,486,481		2,486,481
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS	496,608		496,608		496,608
37	OPERATING ROOM	784,226		784,226		784,226
40	ANESTHESIOLOGY	13,395		13,395		13,395
41	RADIOLOGY-DIAGNOSTIC	1,257,943		1,257,943		1,257,943
44	LABORATORY	952,198		952,198		952,198
49	RESPIRATORY THERAPY	555,156		555,156		555,156
50	PHYSICAL THERAPY	381,990		381,990		381,990
55	MEDICAL SUPPLIES CHARGED	875,290		875,290		875,290
56	DRUGS CHARGED TO PATIENTS	696,695		696,695		696,695
59	SNF PT	1		1		1
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	587,581		587,581		587,581
61	EMERGENCY	1,909,554		1,909,554		1,909,554
62	OBSERVATION BEDS (NON-DIS	429,782		429,782		429,782
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	1,436,681		1,436,681		1,436,681
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	12,863,581		12,863,581		12,863,581
102	LESS OBSERVATION BEDS	429,782		429,782		429,782
103	TOTAL	12,433,799		12,433,799		12,433,799

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	961,244		961,244			
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS	472,914		472,914			
37	OPERATING ROOM		775,877	775,877	1.010761	1.010761	1.010761
40	ANESTHESIOLOGY		23,255	23,255	.576005	.576005	.576005
41	RADIOLOGY-DIAGNOSTIC	308,049	5,169,022	5,477,071	.229674	.229674	.229674
44	LABORATORY	445,148	4,589,719	5,034,867	.189121	.189121	.189121
49	RESPIRATORY THERAPY	319,561	1,338,138	1,657,699	.334896	.334896	.334896
50	PHYSICAL THERAPY	32,555	223,536	256,091	1.491618	1.491618	1.491618
55	MEDICAL SUPPLIES CHARGED	187,060	265,393	452,453	1.934543	1.934543	1.934543
56	DRUGS CHARGED TO PATIENTS	526,334	1,024,719	1,551,053	.449175	.449175	.449175
59	SNF PT	93,547		93,547	.000011	.000011	.000011
60	OUTPAT SERVICE COST CNTRS CLINIC		1,023,307	1,023,307	.574198	.574198	.574198
61	EMERGENCY	38,355	3,651,703	3,690,058	.517486	.517486	.517486
62	OBSERVATION BEDS (NON-DIS		177,696	177,696	2.418636	2.418636	2.418636
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS		954,896	954,896	1.504542	1.504542	1.504542
101	SUBTOTAL	3,384,767	19,217,261	22,602,028			
102	LESS OBSERVATION BEDS						
103	TOTAL	3,384,767	19,217,261	22,602,028			

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

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET C
 I I TO 6/30/2009 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	784,226	140,611	643,615			784,226
40	ANESTHESIOLOGY	13,395	1,684	11,711			13,395
41	RADIOLOGY-DIAGNOSTIC	1,257,943	160,829	1,097,114			1,257,943
44	LABORATORY	952,198	38,607	913,591			952,198
49	RESPIRATORY THERAPY	555,156	26,043	529,113			555,156
50	PHYSICAL THERAPY	381,990	20,323	361,667			381,990
55	MEDICAL SUPPLIES CHARGED	875,290	33,266	842,024			875,290
56	DRUGS CHARGED TO PATIENTS	696,695	23,604	673,091			696,695
59	SNF PT	1		1			1
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	587,581	18,153	569,428			587,581
61	EMERGENCY	1,909,554	44,617	1,864,937			1,909,554
62	OBSERVATION BEDS (NON-DIS	429,782		429,782			429,782
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC	1,436,681	54,985	1,381,696			1,436,681
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	9,880,492	562,722	9,317,770			9,880,492
102	LESS OBSERVATION BEDS	429,782		429,782			429,782
103	TOTAL	9,450,710	562,722	8,887,988			9,450,710

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

IN LIEU OF FORM CMS-2552-96(09/2000)
 I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET C
 I I TO 6/30/2009 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	775,877	1.010761	1.010761
40	ANESTHESIOLOGY	23,255	.576005	.576005
41	RADIOLOGY-DIAGNOSTIC	5,477,071	.229674	.229674
44	LABORATORY	5,034,867	.189121	.189121
49	RESPIRATORY THERAPY	1,657,699	.334896	.334896
50	PHYSICAL THERAPY	256,091	1.491618	1.491618
55	MEDICAL SUPPLIES CHARGED	452,453	1.934543	1.934543
56	DRUGS CHARGED TO PATIENTS	1,551,053	.449175	.449175
59	SNF PT	93,547	.000011	.000011
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1,023,307	.574198	.574198
61	EMERGENCY	3,690,058	.517486	.517486
62	OBSERVATION BEDS (NON-DIS	177,696	2.418636	2.418636
63	OTHER OUTPATIENT SERVICE			
63 50	RURAL HEALTH CLINIC	954,896	1.504542	1.504542
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	21,167,870		
102	LESS OBSERVATION BEDS	177,696		
103	TOTAL	20,990,174		

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

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET C
 I I TO 6/30/2009 I PART II

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

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	784,226	140,611	643,615			784,226
40	ANESTHESIOLOGY	13,395	1,684	11,711			13,395
41	RADIOLOGY-DIAGNOSTIC	1,257,943	160,829	1,097,114			1,257,943
44	LABORATORY	952,198	38,607	913,591			952,198
49	RESPIRATORY THERAPY	555,156	26,043	529,113			555,156
50	PHYSICAL THERAPY	381,990	20,323	361,667			381,990
55	MEDICAL SUPPLIES CHARGED	875,290	33,266	842,024			875,290
56	DRUGS CHARGED TO PATIENTS	696,695	23,604	673,091			696,695
59	SNF PT	1		1			1
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	587,581	18,153	569,428			587,581
61	EMERGENCY	1,909,554	44,617	1,864,937			1,909,554
62	OBSERVATION BEDS (NON-DIS	429,782		429,782			429,782
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	1,436,681	54,985	1,381,696			1,436,681
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	9,880,492	562,722	9,317,770			9,880,492
102	LESS OBSERVATION BEDS	429,782		429,782			429,782
103	TOTAL	9,450,710	562,722	8,887,988			9,450,710

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

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET C
 I I TO 6/30/2009 I PART II

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

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	775,877	1.010761	1.010761
40	ANESTHESIOLOGY	23,255	.576005	.576005
41	RADIOLOGY-DIAGNOSTIC	5,477,071	.229674	.229674
44	LABORATORY	5,034,867	.189121	.189121
49	RESPIRATORY THERAPY	1,657,699	.334896	.334896
50	PHYSICAL THERAPY	256,091	1.491618	1.491618
55	MEDICAL SUPPLIES CHARGED	452,453	1.934543	1.934543
56	DRUGS CHARGED TO PATIENTS	1,551,053	.449175	.449175
59	SNF PT	93,547	.000011	.000011
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1,023,307	.574198	.574198
61	EMERGENCY	3,690,058	.517486	.517486
62	OBSERVATION BEDS (NON-DIS	177,696	2.418636	2.418636
63	OTHER OUTPATIENT SERVICE			
63 50	RURAL HEALTH CLINIC	954,896	1.504542	1.504542
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	21,167,870		
102	LESS OBSERVATION BEDS	177,696		
103	TOTAL	20,990,174		

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET C
 I I TO 6/30/2009 I PART III

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

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	348,843	370,613			
40	ANESTHESIOLOGY	8,150	17,482			
41	RADIOLOGY-DIAGNOSTIC	663,954	2,751,174			
44	LABORATORY	466,371	2,435,102			
49	RESPIRATORY THERAPY	260,746	771,820			
50	PHYSICAL THERAPY	185,853	126,080			
55	MEDICAL SUPPLIES CHARGED	416,927	249,895			
56	DRUGS CHARGED TO PATIENTS	328,539	759,385			
59	SNF PT		748,376			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	285,980	494,357			
61	EMERGENCY	905,105	1,783,848			
62	OBSERVATION BEDS (NON-DIS	242,685	94,941			
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	704,119	443,478			
	OTHER REIMBURS COST CNTRS					
101	TOTAL	4,817,272	11,046,551			

COMPUTATION OF OUTPATIENT COST PER VISIT -
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET C
I I TO 6/30/2009 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	348,843	6,000	354,843	370,613			
40	ANESTHESIOLOGY	8,150	22,819	30,969	17,482			
41	RADIOLOGY-DIAGNOSTIC	663,954		663,954	2,751,174			
44	LABORATORY	466,371	11,721	478,092	2,435,102			
49	RESPIRATORY THERAPY	260,746	22,050	282,796	771,820			
50	PHYSICAL THERAPY	185,853		185,853	126,080			
55	MEDICAL SUPPLIES CHARGED	416,927		416,927	249,895			
56	DRUGS CHARGED TO PATIENTS	328,539		328,539	759,385			
59	SNF PT				748,376			
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	285,980		285,980	494,357			
61	EMERGENCY	905,105	428,442	1,333,547	1,783,848			
62	OBSERVATION BEDS (NON-DIS	242,685		242,685	94,941			
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	4,113,153	491,032	4,604,185	10,603,073			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS
 I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART V
 I 14-1321 I I

TITLE XVIII, PART B HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	1.010761		1.010761		
40 ANESTHESIOLOGY	.576005		.576005		
41 RADIOLOGY-DIAGNOSTIC	.229674		.229674		
44 LABORATORY	.189121		.189121		
49 RESPIRATORY THERAPY	.334896		.334896		
50 PHYSICAL THERAPY	1.491618		1.491618		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.934543		1.934543		
56 DRUGS CHARGED TO PATIENTS	.449175		.449175		
59 SNF PT	.000011		.000011		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	.574198		.574198		
61 EMERGENCY	.517486		.517486		
62 OBSERVATION BEDS (NON-DISTINCT PART)	2.418636		2.418636		
63 OTHER OUTPATIENT SERVICE COST CENTER					
50 63 RURAL HEALTH CLINIC					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS
 I PROVIDER NO: 14-1321 I PERIOD: FROM 7/ 1/2008 I TO 6/30/2009 I
 I COMPONENT NO: 14-1321 I I PREPARED 12/ 8/2009 I WORKSHEET D PART V I

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		445,983			
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		1,939,422			
44 LABORATORY		1,961,476			
49 RESPIRATORY THERAPY		565,331			
50 PHYSICAL THERAPY		85,634			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		183,954			
56 DRUGS CHARGED TO PATIENTS		585,101			
59 SNF PT					
OUTPAT SERVICE COST CNTRS					
60 CLINIC		982,991			
61 EMERGENCY		1,220,075			
62 OBSERVATION BEDS (NON-DISTINCT PART)		131,143			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
101 SUBTOTAL		8,101,110			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		8,101,110			

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART V
 I 14-1321 I I

TITLE XVIII, PART B

HOSPITAL

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

Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	450,782		
40 ANESTHESIOLOGY			
41 RADIOLOGY-DIAGNOSTIC	445,435		
44 LABORATORY	370,956		
49 RESPIRATORY THERAPY	189,327		
50 PHYSICAL THERAPY	127,733		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	355,867		
56 DRUGS CHARGED TO PATIENTS	262,813		
59 SNF PT			
OUTPAT SERVICE COST CNTRS			
60 CLINIC	564,431		
61 EMERGENCY	631,372		
62 OBSERVATION BEDS (NON-DISTINCT PART)	317,187		
63 OTHER OUTPATIENT SERVICE COST CENTER			
50 63 RURAL HEALTH CLINIC			
101 SUBTOTAL	3,715,903		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104 NET CHARGES	3,715,903		

(A) WORKSHEET A LINE NUMBERS

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

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL

IN LIEU OF FORM CMS-2552-96(08/2000) CONTD

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 12/ 8/2009
I	14-1321	I	FROM 7/ 1/2008	I	WORKSHEET D
I	COMPONENT NO:	I	TO 6/30/2009	I	PART VI
I	14-1321	I		I	

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

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

1
.449175

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART II
 I 14-6088 I I

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART II
 I 14-6088 I

TITLE XVIII, PART A SKILLED NURSING FACILITY

PPS

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

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

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

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			775,877				
40	ANESTHESIOLOGY			23,255				
41	RADIOLOGY-DIAGNOSTIC			5,477,071			5,668	
44	LABORATORY			5,034,867			14,437	
49	RESPIRATORY THERAPY			1,657,699				
50	PHYSICAL THERAPY			256,091				
55	MEDICAL SUPPLIES CHARGED			452,453				
56	DRUGS CHARGED TO PATIENTS			1,551,053			27,614	
59	SNF PT			93,547			73,367	
	OUTPAT SERVICE COST CNTRS							
60	CLINIC			1,023,307				
61	EMERGENCY			3,690,058				
62	OBSERVATION BEDS (NON-DIS			177,696				
63	OTHER OUTPATIENT SERVICE							
63	50 RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL			20,212,974			121,086	

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART V
 I 14-1321 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	1.010761				59,266
40 ANESTHESIOLOGY	.576005				8,288
41 RADIOLOGY-DIAGNOSTIC	.229674				1,336,137
44 LABORATORY	.189121				1,018,841
49 RESPIRATORY THERAPY	.334896				257,471
50 PHYSICAL THERAPY	1.491618				66,856
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.934543				26,941
56 DRUGS CHARGED TO PATIENTS	.449175				190,419
59 SNF PT	.000011				
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC	.574198				
62 EMERGENCY	.517486				1,210,002
63 OBSERVATION BEDS (NON-DISTINCT PART)	2.418636				36,211
63 50 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC	1.504542				
101 SUBTOTAL					4,210,432
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					4,210,432

(A) WORKSHEET A LINE NUMBERS

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

APPORIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART V
 I 14-1321 I I

TITLE XIX - O/P

HOSPITAL

	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
Cost Center Description	5.01	5.02	5.03	6	7
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
59 SNF PT					
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					
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)

APPORIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS
 I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 6/30/2009 I PART V
 I 14-1321 I I

TITLE XIX - O/P HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
	8	9	9.01	9.02	9.03
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		59,904			
40 ANESTHESIOLOGY		4,774			
41 RADIOLOGY-DIAGNOSTIC		306,876			
44 LABORATORY		192,684			
49 RESPIRATORY THERAPY		86,226			
50 PHYSICAL THERAPY		99,724			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		52,119			
56 DRUGS CHARGED TO PATIENTS		85,531			
59 SNF PT					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY		626,159			
62 OBSERVATION BEDS (NON-DISTINCT PART)		87,581			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
101 SUBTOTAL		1,601,578			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		1,601,578			

(A) WORKSHEET A LINE NUMBERS

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPDNENT NO: I TO 6/30/2009 I PART I
 I 14-1321 I I

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	1,429
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,346
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,346
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	42
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)	41
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	995
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	42
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)	41
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,486,481
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	144,421
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,342,060

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	961,244
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	961,244
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.436489
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	714.15
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	2,342,060

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART II
 I 14-1321 I I

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,740.01
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,731,310
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,731,310

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT					
HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					716,846
					2,448,156

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

PROGRAM INPATIENT ROUTINE SWING BED COST

60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS) 73,080
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS) 71,340
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 144,420
 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 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART III
 I 14-1321 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 247
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,740.01
- 85 OBSERVATION BED COST 429,782

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART I
 I 14-6088 I

TITLE XVIII PART A SNF PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,358
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,358
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,358
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	661
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	496,608
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	496,608

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,279,268
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,279,268
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.151439
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	976.55
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	496,608

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART III
 I 14-6088 I I

TITLE XVIII PART A

SNF

PPS

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1	496,608
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	147.89	
68	PROGRAM ROUTINE SERVICE COST	97,755	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	97,755	
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	97,755	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	97,755	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		
78	INPATIENT ROUTINE SERVICE COST LIMITATION		
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	97,755	
80	PROGRAM INPATIENT ANCILLARY SERVICES	16,437	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION		
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	114,192	

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART I
 I 14-6088 I

TITLE XIX - I/P SNF PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,358
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,358
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,358
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,786
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,249,077
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,249,077
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	967.56
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	

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 6/30/2009 I PART III
 I 14-6088 I

TITLE XIX - I/P

SNF

PPS

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
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM
- 85 OBSERVATION BED COST

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2009 I
 I 14-1321 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		780,333	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	1.010761		
40	ANESTHESIOLOGY	.576005		
41	RADIOLOGY-DIAGNOSTIC	.229674	224,023	51,452
44	LABORATORY	.189121	360,187	68,119
49	RESPIRATORY THERAPY	.334896	261,816	87,681
50	PHYSICAL THERAPY	1.491618	23,506	35,062
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.934543	152,827	295,650
56	DRUGS CHARGED TO PATIENTS	.449175	398,246	178,882
59	SNF PT OUTPAT SERVICE COST CNTRS	.000011		
60	CLINIC	.574198		
61	EMERGENCY	.517486		
62	OBSERVATION BEDS (NON-DISTINCT PART)	2.418636		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS			
101	TOTAL		1,420,605	716,846
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,420,605	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2009 I
 I 14-2321 I

TITLE XVIII, PART A

SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	1.010761		
40	ANESTHESIOLOGY	.576005		
41	RADIOLOGY-DIAGNOSTIC	.229674	7,496	1,722
44	LABORATORY	.189121	15,182	2,871
49	RESPIRATORY THERAPY	.334896	9,485	3,176
50	PHYSICAL THERAPY	1.491618	7,833	11,684
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.934543	10,016	19,376
56	DRUGS CHARGED TO PATIENTS	.449175	28,411	12,762
59	SNF PT	.000011		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.574198		
61	EMERGENCY	.517486		
62	OBSERVATION BEDS (NON-DISTINCT PART)	2.418636		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		78,423	51,591
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		78,423	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2009 I
 I 14-6088 I

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	1.010761		
40	ANESTHESIOLOGY	.576005		
41	RADIOLOGY-DIAGNOSTIC	.229674	5,668	1,302
44	LABORATORY	.189121	14,437	2,730
49	RESPIRATORY THERAPY	.334896		
50	PHYSICAL THERAPY	1.491618		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.934543		
56	DRUGS CHARGED TO PATIENTS	.449175	27,614	12,404
59	SNF PT	.000011	73,367	1
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.574198		
61	EMERGENCY	.517486		
62	OBSERVATION BEDS (NON-DISTINCT PART)	2.418636		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		121,086	16,437
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		121,086	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 6/30/2009 I
 I 14-1321 I I

TITLE XIX

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS ANCILLARY SRVC COST CNTRS		67,940	
37	OPERATING ROOM	1.010761		
40	ANESTHESIOLOGY	.576005		
41	RADIOLOGY-DIAGNOSTIC	.229674	27,054	6,214
44	LABORATORY	.189121	40,025	7,570
49	RESPIRATORY THERAPY	.334896	38,794	12,992
50	PHYSICAL THERAPY	1.491618		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.934543	669	1,294
56	DRUGS CHARGED TO PATIENTS	.449175	54,783	24,607
59	SNF PT	.000011		
60	OUTPAT SERVICE COST CNTRS CLINIC	.574198		
61	EMERGENCY	.517486	15,414	7,977
62	OBSERVATION BEDS (NON-DISTINCT PART)	2.418636		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	1.504542		
101	TOTAL		176,739	60,654
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		176,739	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 12/ 8/2009
I	14-1321	I	FROM 7/ 1/2008	I	WDRKSHEET E
I	COMPONENT NO:	I	TO 6/30/2009	I	PART B
I	14-1321	I		I	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,715,903
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	3,715,903

COMPUTATION OF LESSER OF COST OR CHARGES

6	REASONABLE CHARGES	
7	ANCILLARY SERVICE CHARGES	
8	INTERNS AND RESIDENTS SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES	
10	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
13	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
15	RATIO OF LINE 11 TO LINE 12	
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
19	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	3,753,062
20.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

21	CAH DEDUCTIBLES	39,002
22.01	CAH ACTUAL BILLED COINSURANCE	1,226,935
23	LINE 17.01 (SEE INSTRUCTIONS)	
24	SUBTOTAL (SEE INSTRUCTIONS)	2,487,125
25	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
26	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
27	ESRD DIRECT MEDICAL EDUCATION COSTS	
28	SUBTOTAL	2,487,125
29	PRIMARY PAYER PAYMENTS	1,057
30	SUBTOTAL	2,486,068

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

31	COMPOSITE RATE ESRD	
32	BAD DEBTS (SEE INSTRUCTIONS)	396,633
33.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	396,633
33.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
34	SUBTOTAL	2,882,701
35	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
36	OTHER ADJUSTMENTS (SPECIFY)	
37.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
38	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
39	SUBTOTAL	2,882,701
40	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
41	INTERIM PAYMENTS	2,402,897
42.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
43	BALANCE DUE PROVIDER/PROGRAM	479,804
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

IN LIEU OF FORM CMS-2552-96 (11/1998)
 I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 6/30/2009 I
 I 14-1321 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,741,689		2,217,052
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.		24,752		204,884
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	2/27/2009	317,622	2/27/2009	47,964
ADJUSTMENTS TO PROVIDER .02	12/29/2008	48,558	2/27/2009	21,267
ADJUSTMENTS TO PROVIDER .03			12/29/2008	43,863
ADJUSTMENTS TO PROVIDER .04			12/29/2008	31,105
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	2/27/2009	2,836	6/12/2009	84,381
ADJUSTMENTS TO PROGRAM .51	2/12/2009	4,771	6/12/2009	78,857
ADJUSTMENTS TO PROGRAM .52	2/12/2009	108,052		
ADJUSTMENTS TO PROGRAM .53	12/29/2008	6,211		
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		244,310		-19,039
4 TOTAL INTERIM PAYMENTS		2,010,751		2,402,897
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)		252,155		479,804
7 TOTAL MEDICARE PROGRAM LIABILITY		2,262,906		2,882,701

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

IN LIEU OF FORM CMS-2552-96 (11/1998)
 I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 6/30/2009 I
 I 14-6088 I I

TITLE XVIII SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		176,285		
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.		9,622		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	12/29/2008	7,333	
ADJUSTMENTS TO PROVIDER	.02			
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROGRAM	.50			
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99		7,333	NONE
4 TOTAL INTERIM PAYMENTS			193,240	
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)			7,333	
7 TOTAL MEDICARE PROGRAM LIABILITY			185,907	

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 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 6/30/2009 I
 I 14-Z321 I

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		162,821		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01	2/27/2009		
ADJUSTMENTS TO PROVIDER	.02	12/29/2008		
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROGRAM	.50	6/12/2009		14,974
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99			1,196
4 TOTAL INTERIM PAYMENTS				164,017
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)				33,820
SETTLEMENT TO PROVIDER	.01			
SETTLEMENT TO PROGRAM	.02			
7 TOTAL MEDICARE PROGRAM LIABILITY				197,837

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

IN LIEU OF FORM CMS-2552-96-E-2 (05/2004)
 I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I
 I COMPONENT NO: I TO 6/30/2009 I WORKSHEET E-2
 I 14-2321 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)	145,864	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	52,107	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	83	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	197,971	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	197,971	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	197,971	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	134	
14	80% OF PART B COSTS		
15	SUBTOTAL	197,837	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	197,837	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	164,017	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	33,820	
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 12/ 8/2009
I	14-1321	I	FROM 7/ 1/2008	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2009	I	PART II
I	14-1321	I		I	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,448,156
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,448,156
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,472,638

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 LIA BLE	
13	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE	
13	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT	
13	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	2,472,638
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	229,258
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,243,380
23	COINSURANCE	3,072
24	SUBTOTAL	2,240,308
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL	22,598
25	SERVICES (SEE INSTRUCTIONS)	
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	22,598
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	2,262,906
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER	
27	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS	
29	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	2,262,906
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,010,751
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	252,155
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)	
34	IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET E-3
 I COMPONENT NO: I TO 6/30/2009 I PART III
 I 14-6088 I I

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

	IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)		
I	PROVIDER NO:	I PERIOD:	I PREPARED 12/ 8/2009
I	14-1321	I FROM 7/ 1/2008	I WORKSHEET E-3
I	COMPONENT NO:	I TO 6/30/2009	I PART III
I	14-6088	I	I

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

TITLE XVIII

SNF

PPS
TITLE V OR
TITLE XIX
1

TITLE XVIII
SNF PPS
2

-7,333

- 58 BALANCE DUE PROVIDER/PROGRAM
- 59 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)
IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

BALANCE SHEET

IN LIEU OF FORM CMS-2552-96 (06/2003)

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	165,941			
2	TEMPORARY INVESTMENTS	232,194			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	4,833,376			
5	OTHER RECEIVABLES	1,706,987			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,268,394			
7	INVENTORY	164,573			
8	PREPAID EXPENSES	77,329			
9	OTHER CURRENT ASSETS	871,307			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	5,783,313			
FIXED ASSETS					
12	LAND				
12.01	LAND IMPROVEMENTS				
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	15,154,690			
14.01	LESS ACCUMULATED DEPRECIATION	-12,427,228			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	2,727,462			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	59,550			
26	TOTAL OTHER ASSETS	59,550			
27	TOTAL ASSETS	8,570,325			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE			
	1,449,730			
29	SALARIES, WAGES & FEES PAYABLE			
	695,833			
30	PAYROLL TAXES PAYABLE			
31	NOTES AND LOANS PAYABLE (SHORT TERM)			
	750,710			
32	DEFERRED INCOME			
33	ACCELERATED PAYMENTS			
34	DUE TO OTHER FUNDS			
	765,460			
35	OTHER CURRENT LIABILITIES			
	336,569			
36	TOTAL CURRENT LIABILITIES			
	3,998,302			
LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE			
38	NOTES PAYABLE			
	3,335,093			
39	UNSECURED LOANS			
40.01	LOANS PRIOR TO 7/1/66			
40.02	ON OR AFTER 7/1/66			
41	OTHER LONG TERM LIABILITIES			
42	TOTAL LONG-TERM LIABILITIES			
	3,335,093			
43	TOTAL LIABILITIES			
	7,333,395			
CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE			
	1,236,930			
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			
	1,236,930			
52	TOTAL LIABILITIES AND FUND BALANCES			
	8,570,325			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING		853,687		
2 OF PERIOD				
2 NET INCOME (LOSS)		-646,170		
3 TOTAL		207,517		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM	1,029,413			
6				
7				
8				
9				
10 TOTAL ADDITIONS		1,029,413		
11 SUBTOTAL		1,236,930		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF		1,236,930		
PERIOD PER BALANCE SHEET				

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET G-2
 I I TO 6/30/2009 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	961,244		961,244
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY	472,914		472,914
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	1,434,158		1,434,158
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	1,434,158		1,434,158
17 00 ANCILLARY SERVICES	1,950,609	18,311,455	20,262,064
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC		954,896	954,896
24 00 PRO FEES	9,131	1,522,948	1,532,079
25 00 TOTAL PATIENT REVENUES	3,393,898	20,789,299	24,183,197

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES	14,104,570
ADD (SPECIFY)	
27 00 BAD DEBT	
28 00	
29 00	
30 00	
31 00	
32 00	
33 00 TOTAL ADDITIONS	
DEDUCT (SPECIFY)	
34 00 DEDUCT (SPECIFY)	
35 00	
36 00	
37 00	
38 00	
39 00 TOTAL DEDUCTIONS	
40 00 TOTAL OPERATING EXPENSES	14,104,570

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET G-3
 I I TO 6/30/2009 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	24,183,197
2	LESS: ALLOWANCES AND DISCOUNTS ON	12,496,980
3	NET PATIENT REVENUES	11,686,217
4	LESS: TOTAL OPERATING EXPENSES	14,104,570
5	NET INCOME FROM SERVICE TO PATIENT	-2,418,353
	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 SOLO TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER (SPECIFY)	990,625
24.01		781,558
25	TOTAL OTHER INCOME	1,772,183
26	TOTAL	-646,170
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	-646,170

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

IN LIEU OF FORM CMS-2552-96 M-1 (11/1998)
I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET M-1
I COMPONENT NO: I TO 6/30/2009 I
I 14-3469 I I

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	251,280	251,280	
2	PHYSICIAN ASSISTANT	58,695	58,695	
3	NURSE PRACTITIONER	135,033	135,033	
4	VISITING NURSE			
5	OTHER NURSE	154,333	154,333	
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	599,341	599,341	
COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES			
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)			
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	599,341	599,341	
COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
FACILITY OVERHEAD				
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	85,412	122,796	-4,480
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	85,412	122,796	-4,480
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	684,753	722,137	-4,480

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

IN LIEU OF FORM CMS-2552-96 M-1 (11/1998)
I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET M-1
I COMPONENT NO: I TO 6/30/2009 I
I 14-3469 I I

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	251,280	251,280
2	PHYSICIAN ASSISTANT	58,695	58,695
3	NURSE PRACTITIONER	135,033	135,033
4	VISITING NURSE		
5	OTHER NURSE	154,333	154,333
6	CLINICAL PSYCHOLOGIST		
7	CLINICAL SOCIAL WORKER		
8	LABORATORY TECHNICIAN		
9	OTHER FACILITY HEALTH CARE STAFF COSTS		
10	SUBTOTAL (SUM OF LINES 1-9)	599,341	599,341
COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT		
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		
13	OTHER COSTS UNDER AGREEMENT		
14	SUBTOTAL (SUM OF LINES 11-13)		
OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES		
16	TRANSPORTATION (HEALTH CARE STAFF)		
17	DEPRECIATION-MEDICAL EQUIPMENT		
18	PROFESSIONAL LIABILITY INSURANCE		
19	OTHER HEALTH CARE COSTS		
20	ALLOWABLE GME COSTS		
21	SUBTOTAL (SUM OF LINES 15-20)		
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	599,341	599,341
COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY		
24	DENTAL		
25	OPTOMETRY		
26	ALL OTHER NONREIMBURSABLE COSTS		
27	NONALLOWABLE GME COSTS		
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		
FACILITY OVERHEAD			
29	FACILITY COSTS		
30	ADMINISTRATIVE COSTS	118,316	118,316
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	118,316	118,316
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	717,657	717,657

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
I 14-1321 I FROM 7/ 1/2008 I WORKSHEET M-2
I COMPONENT NO: I TO 6/30/2009 I
I 14-3469 I I

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4	
POSITIONS					
1	PHYSICIANS	1.12	4,008	4,200	4,704
2	PHYSICIAN ASSISTANTS	.78	1,849	2,100	1,638
3	NURSE PRACTITIONERS	1.28	3,779	2,100	2,688
4	SUBTOTAL (SUM OF LINES 1-3)	3.18	9,636		9,030
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	3.18	9,636		
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)	599,341			
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	599,341			
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000			
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	118,316			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	719,024			
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	837,340			
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	837,340			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	837,340			
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,436,681			

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 12/ 8/2009
I	14-1321	I	FROM 7/ 1/2008	I	WORKSHEET M-2
I	COMPONENT NO:	I	TO 6/30/2009	I	
I	14-3469	I		I	

RHC 1

VISITS AND PRODUCTIVITY

GREATER OF
COL. 2 OR
COL. 4
5

POSITIONS		
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	9,636
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	9,636
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

I PROVIDER NO:	I PERIOD:	I PREPARED 12/ 8/2009
I 14-1321	I FROM 7/ 1/2008	I WORKSHEET M-3
I COMPONENT NO:	I TO 6/30/2009	I
I 14-3469	I	I

TITLE XVIII RHC 1

DETERMINATION OF RATE FOR RHC/FQHC SERVICES		
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	1,436,681
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,436,681
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	9,636
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	9,636
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	149.10

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)	149.10
CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	2,525
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	376,478
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)	
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)	
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)	
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*	376,478
16.01	PRIMARY PAYER AMOUNT	259
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	27,404
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	348,815
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	279,052
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	279,052
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	279,052
25	INTERIM PAYMENTS	290,710
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	-11,658
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2	

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

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

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

IN LIEU OF FORM CMS-2552-96 M-5 (11/1998)
 I PROVIDER NO: I PERIOD: I PREPARED 12/ 8/2009
 I 14-1321 I FROM 7/ 1/2008 I WORKSHEET M-5
 I COMPONENT NO: I TO 6/30/2009 I
 I 14-3469 I

RHC 1

DESCRIPTION	P A R T		B AMOUNT
	MM/DD/YYYY		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1	212,367
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	12/28/2008	43,661
ADJUSTMENTS TO PROVIDER	.02	2/28/2009	34,682
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		78,343
4 TOTAL INTERIM PAYMENTS			290,710
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
TENTATIVE TO PROVIDER	.01		
TENTATIVE TO PROVIDER	.02		
TENTATIVE TO PROVIDER	.03		
TENTATIVE TO PROGRAM	.50		
TENTATIVE TO PROGRAM	.51		
TENTATIVE TO PROGRAM	.52		
SUBTOTAL	.99		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			
SETTLEMENT TO PROVIDER	.01		
SETTLEMENT TO PROGRAM	.02		11,658
7 TOTAL MEDICARE PROGRAM LIABILITY			279,052

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.