

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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	14-1323	I	FROM 4/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 3/31/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 8/24/2009 TIME 10:14

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:
MASSAC MEMORIAL HOSPITAL 14-1323
FOR THE COST REPORTING PERIOD BEGINNING 4/ 1/2008 AND ENDING 3/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 8/24/2009 TIME 10:14

Sbx1hD2iNwwyoh7w8EicVfCoppEC0
YJtmh0QVaeYveNygxFmLy8AphwEa1D
RqkTOYCDJi0USMO.

PI ENCRYPTION INFORMATION
DATE: 8/24/2009 TIME 10:14

OzMuyZYoOnOIC:wYoTMII2AyxvTVY0
UzcOD0yiiCG8VatKXK0e.Jnky3NrnN
V7ec3d1JyJ00y8t1

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	83,031	584,664	0	0
3	SWING BED - SNF	0	114,570	0	0	0
9	RHC	0	0	-7,804	0	0
100	TOTAL	0	197,601	576,860	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.

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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	14-1323	I	FROM 4/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 3/31/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 8/17/2009 TIME 18:05

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:
MASSAC MEMORIAL HOSPITAL 14-1323
FOR THE COST REPORTING PERIOD BEGINNING 4/ 1/2008 AND ENDING 3/31/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1	HOSPITAL	0	83,031	584,664	0	0
3	SWING BED - SNF	0	114,570	0	0	0
9	RHC	0	0	-7,804	0	0
100	TOTAL	0	197,601	576,860	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 AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

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

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 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	14-1323	2.01	2/ 1/2003	4	5	6
04.00	SWING BED - SNF	14-2323		2/ 1/2003	N	O	O
14.00	HOSPITAL-BASED RHC	14-3478		2/ 7/2006	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 4/ 1/2008 TO: 3/31/2009 1 2
 18 TYPE OF CONTROL 11

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

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

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

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC 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 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 \$5105 OR MIPPA \$147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO. N
 N
 N

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER?

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

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? N

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

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

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

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

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

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

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / / 0
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / / / /
 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 2/ 1/2003

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

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

	1	2	3	4
28.02	0	0.0000	0.0000	
	0.00	0		

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

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

	%	Y/N
28.03 STAFFING	0.00%	
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) Y

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

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

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

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

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

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

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

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

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

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

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

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

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

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

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

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 280,791
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0

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

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

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
 58 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST 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) N 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). / /

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	I/P DAYS / TITLE V	O/P VISITS / TITLE XVIII	NOT LTCH N/A	TRIPS / TITLE XIX
1 ADULTS & PEDIATRICS	19	6,935	78,412.32	3	2,200	4.01	255
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)					495		
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	19	6,935	78,412.32		2,695		255
6 INTENSIVE CARE UNIT	6	2,190	5,564.68		335		44
12 TOTAL	25	9,125	83,977.00		3,030		299
13 RPCH VISITS							
24 RURAL HEALTH CLINIC					485		3,111
25 TOTAL	25						
26 OBSERVATION BED DAYS							46
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL ADMITTED	DISCHARGES / TOTAL OBSERVATION BEDS NOT ADMITTED	INTERNS & RES. FTES -- TOTAL	LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			2,974				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			545				
4 ADULTS & PED-SB NF			54				
5 TOTAL ADULTS AND PEDS			3,573				
6 INTENSIVE CARE UNIT			495				
12 TOTAL			4,068				
13 RPCH VISITS							
24 RURAL HEALTH CLINIC			4,876				
25 TOTAL							
26 OBSERVATION BED DAYS	1	45	425	2	423		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET	--- FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	DISCHARGES / TITLE V	DISCHARGES / TITLE XVIII	DISCHARGES / TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					597	98	925
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
12 TOTAL		175.25			597	98	925
13 RPCH VISITS							
24 RURAL HEALTH CLINIC		3.27					
25 TOTAL		178.52					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

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

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

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

	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	DR. MICHAEL KLOEP	104.00

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

FACILITY HOURS OF OPERATIONS (1)

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

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

TITLE V TITLE XVIII TITLE XIX

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

17 HAS THE 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 8/17/2009
I 14-1323 I FROM 4/ 1/2008 I WORKSHEET A
I I TO 3/31/2009 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		391,070	391,070	154,139	545,209
3.01	0301 NEW CAP REL COSTS-BLDG AMBULANCE				24,000	24,000
3.02	0302 NEW CAP REL COSTS-BLDG EKG				14,494	14,494
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		736,758	736,758	443,488	1,180,246
5	0500 EMPLOYEE BENEFITS	99,651	2,629,145	2,728,796		2,728,796
6	0600 ADMINISTRATIVE & GENERAL	1,061,866	1,006,633	2,068,499	-98,188	1,970,311
8	0800 OPERATION OF PLANT	259,051	681,551	940,602	-24,520	916,082
9	0900 LAUNDRY & LINEN SERVICE	58,808	22,474	81,282		81,282
10	1000 HOUSEKEEPING	252,089	66,837	318,926		318,926
11	1100 DIETARY	249,502	163,948	413,450	-184,229	229,221
12	1200 CAFETERIA				183,158	183,158
14	1400 NURSING ADMINISTRATION	470,711	13,095	483,806		483,806
17	1700 MEDICAL RECORDS & LIBRARY	201,846	31,766	233,612		233,612
18	1800 SOCIAL SERVICE	143,262	14,213	157,475		157,475
20	2000 NONPHYSICIAN ANESTHETISTS					
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	867,313	214,329	1,081,642		1,081,642
26	2600 INTENSIVE CARE UNIT	497,759	8,303	506,062	-1,802	504,260
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	200,862	183,217	384,079	-109,527	274,552
40	4000 ANESTHESIOLOGY		224,907	224,907		224,907
41	4100 RADIOLOGY-DIAGNOSTIC	510,126	735,159	1,245,285	-260,046	985,239
44	4400 LABORATORY	408,734	535,314	944,048	-33,424	910,624
49	4900 RESPIRATORY THERAPY	288,524	98,714	387,238	-19,796	367,442
50	5000 PHYSICAL THERAPY	392,392	10,845	403,237	-1,712	401,525
53	5300 ELECTROCARDIOLOGY	102,473	151,132	253,605	3,041	256,646
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	62,789	16,653	79,442	90,964	170,406
56	5600 DRUGS CHARGED TO PATIENTS	202,325	416,272	618,597	-10,795	607,802
	OUTPAT SERVICE COST CNTRS					
61	6100 EMERGENCY	496,540	1,307,281	1,803,821	60,158	1,863,979
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	176,621	73,323	249,944		249,944
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES	472,792	95,895	568,687	-27,293	541,394
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		215,129	215,129	-215,129	
90	9000 OTHER CAPITAL RELATED COSTS		44,277	44,277	-44,277	
95	SUBTOTALS	7,476,036	10,088,240	17,564,276	-57,296	17,506,980
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES	42,140	9,464	51,604	57,296	108,900
98.01	9801 PROMOTION					
99	9900 NONPAID WORKERS					
101	TOTAL	7,518,176	10,097,704	17,615,880	-0-	17,615,880

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
I 14-1323 I FROM 4/ 1/2008 I WORKSHEET A
I I TO 3/31/2009 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-51,511	493,698
3.01	0301 NEW CAP REL COSTS-BLDG AMBULANCE		24,000
3.02	0302 NEW CAP REL COSTS-BLDG EKG		14,494
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-22,812	1,157,434
5	0500 EMPLOYEE BENEFITS	-204	2,728,592
6	0600 ADMINISTRATIVE & GENERAL	-113,372	1,856,939
8	0800 OPERATION OF PLANT	-2,037	914,045
9	0900 LAUNDRY & LINEN SERVICE		81,282
10	1000 HOUSEKEEPING		318,926
11	1100 DIETARY	-501	228,720
12	1200 CAFETERIA	-71,156	112,002
14	1400 NURSING ADMINISTRATION		483,806
17	1700 MEDICAL RECORDS & LIBRARY	-2,100	231,512
18	1800 SOCIAL SERVICE		157,475
20	2000 NONPHYSICIAN ANESTHETISTS		
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-85,835	995,807
26	2600 INTENSIVE CARE UNIT		504,260
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		274,552
40	4000 ANESTHESIOLOGY	-156,647	68,260
41	4100 RADIOLOGY-DIAGNOSTIC		985,239
44	4400 LABORATORY		910,624
49	4900 RESPIRATORY THERAPY		367,442
50	5000 PHYSICAL THERAPY		401,525
53	5300 ELECTROCARDIOLOGY	-73,558	183,088
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-6,937	163,469
56	5600 DRUGS CHARGED TO PATIENTS	-3,552	604,250
	OUTPAT SERVICE COST CNTRS		
61	6100 EMERGENCY	-695,503	1,168,476
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC		249,944
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES	-3,470	537,924
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-1,289,195	16,217,785
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		108,900
98.01	9801 PROMOTION		
99	9900 NONPAID WORKERS		
101	TOTAL	-1,289,195	16,326,685

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 3/31/2009 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
3.01	NEW CAP REL COSTS-BLDG AMBULANCE	0301	NEW CAP REL COSTS-BLDG & FIXT
3.02	NEW CAP REL COSTS-BLDG EKG	0302	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	PROMOTION	9801	PHYSICIANS' PRIVATE OFFICES
99	NONPAID WORKERS	9900	
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141323	FROM 4/ 1/2008	8/17/2009
	TO 3/31/2009	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	INCREASE		
			LINE NO	SALARY	
	1	2	3	4	5
1 TO RECLASS INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		151,957
2		NEW CAP REL COSTS-MVBLE EQUIP	4		63,172
3 TO RECLASS CAFETERIA EXPENSE	B	CAFETERIA	12	110,529	72,629
4 TO RECLASS RENTAL EXPENSE	C	NEW CAP REL COSTS-MVBLE EQUIP	4		368,903
5					
6					
7					
8					
9					
10					
11 TO RECLASS MEDICAL SUPPLY EXPENSE	D	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		95,331
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22 TO RECLASS DRUG COSTS	E	DRUGS CHARGED TO PATIENTS	56		1,071
23 TO RECLASS PROF BUILD COSTS	F	PHYSICIANS' PRIVATE OFFICES	98		30,682
24					
25 TO RECLASS EKG SALARIES	G	ELECTROCARDIOLOGY	53	17,535	
26 TO RECLASS PROFESSIONAL BUILDING CST	J	PHYSICIANS' PRIVATE OFFICES	98	8,048	14,549
27 TO RECLASS REAL ESTATE TAXES	M	PHYSICIANS' PRIVATE OFFICES	98		4,017
28 TO RECLASS ER PHY MALPRACTICE	N	EMERGENCY	61		89,889
29 TO RECLASS AMBULANCE RENTAL EXPENSE	O	NEW CAP REL COSTS-BLDG AMBULANCE	3.01		24,000
30 TO RECLASS SLEEP LAB RENTAL EXPENSE	P	NEW CAP REL COSTS-BLDG EKG	3.02		14,494
36 TOTAL RECLASSIFICATIONS				136,112	930,694

(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: 141323	PERIOD: FROM 4/ 1/2008 TO 3/31/2009	PREPARED 8/17/2009 WORKSHEET A-6
------------------------	---	-------------------------------------

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	88			215,129	11
2							11
3 TO RECLASS CAFETERIA EXPENSE	B	DIETARY	11		110,529	72,629	
4 TO RECLASS RENTAL EXPENSE	C	OPERATION OF PLANT	8			1,923	10
5		RADIOLOGY-DIAGNOSTIC	41			260,046	
6		LABORATORY	44			33,210	
7		PHYSICAL THERAPY	50			1,061	
8		MEDICAL SUPPLIES CHARGED TO PATIENTS	55			3,677	
9		OPERATING ROOM	37			64,704	
10		ADMINISTRATIVE & GENERAL	6			4,282	
11 TO RECLASS MEDICAL SUPPLY EXPENSE	D	INTENSIVE CARE UNIT	26			1,802	
12		OPERATING ROOM	37			327	
13		MEDICAL SUPPLIES CHARGED TO PATIENTS	55			690	
14		LABORATORY	44			214	
15		OPERATING ROOM	37			44,496	
16		RESPIRATORY THERAPY	49			2,261	
17		EMERGENCY	61			29,731	
18		AMBULANCE SERVICES	65			3,293	
19		DRUGS CHARGED TO PATIENTS	56			6,585	
20		DRUGS CHARGED TO PATIENTS	56			5,281	
21		PHYSICAL THERAPY	50			651	
22 TO RECLASS DRUG COSTS	E	DIETARY	11			1,071	
23 TO RECLASS PROF BUILD COSTS	F	NEW CAP REL COSTS-BLDG & FIXT	3			28,797	9
24		NEW CAP REL COSTS-MVBLE EQUIP	4			1,885	9
25 TO RECLASS EKG SALARIES	G	RESPIRATORY THERAPY	49		17,535		
26 TO RECLASS PROFESSIONAL BUILDING CST	J	OPERATION OF PLANT	8		8,048	14,549	
27 TO RECLASS REAL ESTATE TAXES	M	ADMINISTRATIVE & GENERAL	6			4,017	
28 TO RECLASS ER PHY MALPRACTICE	N	ADMINISTRATIVE & GENERAL	6			89,889	
29 TO RECLASS AMBULANCE RENTAL EXPENSE	O	AMBULANCE SERVICES	65			24,000	10
30 TO RECLASS SLEEP LAB RENTAL EXPENSE	P	ELECTROCARDIOLOGY	53			14,494	10
36 TOTAL RECLASSIFICATIONS					136,112	930,694	

(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: 141323

PERIOD: FROM 4/ 1/2008 TO 3/31/2009

PREPARED 8/17/2009 WORKSHEET A-6 NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : TO RECLASS INTEREST EXPENSE

Table with columns: LINE, COST CENTER, LINE, AMOUNT. Rows include NEW CAP REL COSTS-BLDG & FIXT and NEW CAP REL COSTS-MVBLE EQUIP.

Table with columns: COST CENTER, LINE, AMOUNT. Row includes INTEREST EXPENSE.

RECLASS CODE: B
EXPLANATION : TO RECLASS CAFETERIA EXPENSE

Table with columns: LINE, COST CENTER, LINE, AMOUNT. Row includes CAFETERIA.

Table with columns: COST CENTER, LINE, AMOUNT. Row includes DIETARY.

RECLASS CODE: C
EXPLANATION : TO RECLASS RENTAL EXPENSE

Table with columns: LINE, COST CENTER, LINE, AMOUNT. Rows include NEW CAP REL COSTS-MVBLE EQUIP.

Table with columns: COST CENTER, LINE, AMOUNT. Rows include OPERATION OF PLANT, RADIOLOGY-DIAGNOSTIC, LABORATORY, PHYSICAL THERAPY, MEDICAL SUPPLIES CHARGED TO PA, OPERATING ROOM, ADMINISTRATIVE & GENERAL.

RECLASS CODE: D
EXPLANATION : TO RECLASS MEDICAL SUPPLY EXPENSE

Table with columns: LINE, COST CENTER, LINE, AMOUNT. Row includes MEDICAL SUPPLIES CHARGED TO PA.

Table with columns: COST CENTER, LINE, AMOUNT. Rows include INTENSIVE CARE UNIT, OPERATING ROOM, MEDICAL SUPPLIES CHARGED TO PA, LABORATORY, OPERATING ROOM, RESPIRATORY THERAPY, EMERGENCY, AMBULANCE SERVICES, DRUGS CHARGED TO PATIENTS, PHYSICAL THERAPY.

RECLASS CODE: E
EXPLANATION : TO RECLASS DRUG COSTS

Table with columns: LINE, COST CENTER, LINE, AMOUNT. Row includes DRUGS CHARGED TO PATIENTS.

Table with columns: COST CENTER, LINE, AMOUNT. Row includes DIETARY.

RECLASS CODE: F
EXPLANATION : TO RECLASS PROF BUILD COSTS

Table with columns: LINE, COST CENTER, LINE, AMOUNT. Row includes PHYSICIANS' PRIVATE OFFICES.

Table with columns: COST CENTER, LINE, AMOUNT. Rows include NEW CAP REL COSTS-BLDG & FIXT and NEW CAP REL COSTS-MVBLE EQUIP.

RECLASS CODE: G
EXPLANATION : TO RECLASS EKG SALARIES

Table with columns: LINE, COST CENTER, LINE, AMOUNT. Row includes ELECTROCARDIOLOGY.

Table with columns: COST CENTER, LINE, AMOUNT. Row includes RESPIRATORY THERAPY.

RECLASS CODE: J
EXPLANATION : TO RECLASS PROFESSIONAL BUILDING CST

Table with columns: LINE, COST CENTER, LINE, AMOUNT. Row includes PHYSICIANS' PRIVATE OFFICES.

Table with columns: COST CENTER, LINE, AMOUNT. Row includes OPERATION OF PLANT.

RECLASSIFICATIONS

RECLASS CODE: M
EXPLANATION : TO RECLASS REAL ESTATE TAXES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	PHYSICIANS' PRIVATE OFFICES	98	4,017	ADMINISTRATIVE & GENERAL	6	4,017	
TOTAL RECLASSIFICATIONS FOR CODE M			4,017				4,017

RECLASS CODE: N
EXPLANATION : TO RECLASS ER PHY MALPRACTICE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	EMERGENCY	61	89,889	ADMINISTRATIVE & GENERAL	6	89,889	
TOTAL RECLASSIFICATIONS FOR CODE N			89,889				89,889

RECLASS CODE: O
EXPLANATION : TO RECLASS AMBULANCE RENTAL EXPENSE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG AMBULAN	3.01	24,000	AMBULANCE SERVICES	65	24,000	
TOTAL RECLASSIFICATIONS FOR CODE O			24,000				24,000

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

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG EKG	3.02	14,494	ELECTROCARDIOLOGY	53	14,494	
TOTAL RECLASSIFICATIONS FOR CODE P			14,494				14,494

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3					
1	LAND	13,981				13,981		13,981	
2	LAND IMPROVEMENTS	173,980	868,773			1,042,753		1,042,753	
3	BUILDINGS & FIXTURE	16,212,739	10,834,977			27,047,716	7,709,557	19,338,159	
4	BUILDING IMPROVEMEN								
5	FIXED EQUIPMENT								
6	MOVABLE EQUIPMENT	6,834,121	1,914,991			8,749,112		8,749,112	
7	SUBTOTAL	23,234,821	13,618,741			36,853,562	7,709,557	29,144,005	
8	RECONCILING ITEMS								
9	TOTAL	23,234,821	13,618,741			36,853,562	7,709,557	29,144,005	

PART III - RECONCILIATION OF CAPITAL COST CENTERS
 DESCRIPTION

	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL	
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS		
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	20,380,912		20,380,912	.699653	30,979			30,979
3 01	NEW CAP REL COSTS-BL								
3 02	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV	8,749,112		8,749,112	.300347	13,298			13,298
5	TOTAL	29,130,024		29,130,024	1.000000	44,277			44,277

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST	TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES		
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	362,273		100,446	30,979			493,698
3 01	NEW CAP REL COSTS-BL		24,000					24,000
3 02	NEW CAP REL COSTS-BL		14,494					14,494
4	NEW CAP REL COSTS-MV	733,475	368,903	41,758	13,298			1,157,434
5	TOTAL	1,095,748	407,397	142,204	44,277			1,689,626

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST	TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES		
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	391,070						391,070
3 01	NEW CAP REL COSTS-BL							
3 02	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV	736,758						736,758
5	TOTAL	1,127,828						1,127,828

* All lines numbers except line 5 are to be consistent with workshset 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 14-1323
I

I PERIOD:
I FROM 4/ 1/2008 I PREPARED 8/17/2009
I TO 3/31/2009 I WORKSHEET A-8

DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO 4	WKST. A-7 REF. 5
			COST CENTER 3			
1			**COST CENTER DELETED**		1	
2			**COST CENTER DELETED**		2	
3	B	-51,511	NEW CAP REL COSTS-BLDG &		3	11
4	B	-21,414	NEW CAP REL COSTS-MVBLE E		4	11
5						
6						
7						
8						
9	A	-9,305	ADMINISTRATIVE & GENERAL		6	
10						
11						
12	A-8-2	-806,104				
13						
14	A-8-1					
15						
16						
17						
18						
19						
20	A	-2,100	MEDICAL RECORDS & LIBRARY		17	
21						
22						
23						
24						
25	A-8-3/A-8-4		RESPIRATORY THERAPY		49	
26	A-8-3/A-8-4		PHYSICAL THERAPY		50	
27	A-8-3					
28			**COST CENTER DELETED**		89	
29			**COST CENTER DELETED**		1	
30			**COST CENTER DELETED**		2	
31			NEW CAP REL COSTS-BLDG &		3	
32			NEW CAP REL COSTS-MVBLE E		4	
33			NONPHYSICIAN ANESTHETISTS		20	
34						
35	A-8-4		**COST CENTER DELETED**		51	
36	A-8-4		**COST CENTER DELETED**		52	
37	A	-2,037	OPERATION OF PLANT		8	
38	B	-15,534	ADMINISTRATIVE & GENERAL		6	
39	B	-22,084	ADMINISTRATIVE & GENERAL		6	
40	B	-1,594	ADMINISTRATIVE & GENERAL		6	
41	B	-3,552	DRUGS CHARGED TO PATIENTS		56	
42	B	-6,937	MEDICAL SUPPLIES CHARGED		55	
43	B	-71,156	CAFETERIA		12	
44	B	-3,470	AMBULANCE SERVICES		65	
45						
46	A	-10,138	ADMINISTRATIVE & GENERAL		6	
47	A	-156,647	ANESTHESIOLOGY		40	
48	B	-501	DIETARY		11	
49	A	-2,924	ADMINISTRATIVE & GENERAL		6	
49.01	A	-779	NEW CAP REL COSTS-MVBLE E		4	9
49.02	A	-751	ADMINISTRATIVE & GENERAL		6	
49.03	A	-204	EMPLOYEE BENEFITS		5	
49.04	A	-619	NEW CAP REL COSTS-MVBLE E		4	9
49.05	A	-48,792	EMERGENCY		61	
49.06						
49.07	A	-51,042	ADMINISTRATIVE & GENERAL		6	
50		-1,289,195				

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 14-1323
I

I PERIOD:
I FROM 4/ 1/2008
I TO 3/31/2009

I PREPARED 8/17/2009
I WORKSHEET A-8-2
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	44	LABORATORY	11,000		11,000			
3	53	EKG	73,558	73,558				
4	61	EMERGENCY	1,193,928	646,711	547,217			
5	25	HOSPITALIST	85,835	85,835				
6	53	CARDIAC REHAB	14,700		14,700			
7	53	SLEEP LAB	37,778		37,778			
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	1,416,799	806,104	610,695			

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 14-1323
I

I PERIOD:
I FROM 4/ 1/2008
I TO 3/31/2009

I PREPARED 8/17/2009
I WORKSHEET A-8-2
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	44	LABORATORY						
3	53	EKG						73,558
4	61	EMERGENCY						646,711
5	25	HOSPITALIST						85,835
6	53	CARDIAC REHAB						
7	53	SLEEP LAB						
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101		TOTAL						806,104

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 3/31/2009 I

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

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I WORKSHEET B
 I I TO 3/31/2009 I PART I

COST CENTER DESCRIPTION		NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-BLDG AM	NEW CAP REL C OSTS-BLDG EK	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL
		0	3	3.01	3.02	4	5	5a.00
003	GENERAL SERVICE COST CNTR							
	NEW CAP REL COSTS-BLDG &	493,698	493,698					
003 01	NEW CAP REL COSTS-BLDG AM	24,000		24,000				
003 02	NEW CAP REL COSTS-BLDG EK	14,494			14,494			
004	NEW CAP REL COSTS-MVBLE E	1,157,434				1,157,434		
005	EMPLOYEE BENEFITS	2,728,592	4,101			8,957	2,741,650	
006	ADMINISTRATIVE & GENERAL	1,856,939	80,034			174,808	392,431	2,504,212
008	OPERATION OF PLANT	914,045	89,593			195,690	92,763	1,292,091
009	LAUNDRY & LINEN SERVICE	81,282	11,781			25,731	21,734	140,528
010	HOUSEKEEPING	318,926	4,312			9,418	93,164	425,820
011	DIETARY	228,720	12,763			27,876	51,360	320,719
012	CAFETERIA	112,002	6,177			13,492	40,848	172,519
014	NURSING ADMINISTRATION	483,806	5,014			10,952	173,960	673,732
017	MEDICAL RECORDS & LIBRARY	231,512	11,169		1,695	27,562	74,596	346,534
018	SOCIAL SERVICE	157,475					52,945	210,420
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	995,807	83,931			183,320	320,531	1,583,589
026	INTENSIVE CARE UNIT	504,260	13,586			29,674	183,956	731,476
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	274,552	49,895			108,979	74,232	507,658
040	ANESTHESIOLOGY	68,260						68,260
041	RADIOLOGY-DIAGNOSTIC	985,239	32,178			70,283	188,526	1,276,226
044	LABORATORY	910,624	10,474			22,878	151,055	1,095,031
049	RESPIRATORY THERAPY	367,442	6,819			14,895	100,149	489,305
050	PHYSICAL THERAPY	401,525	16,093			35,150	145,016	597,784
053	ELECTROCARDIOLOGY	183,088			12,799	23,917	44,351	264,155
055	MEDICAL SUPPLIES CHARGED	163,469					23,205	186,674
056	DRUGS CHARGED TO PATIENTS	604,250	4,539			9,913	74,773	693,475
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	1,168,476	31,295			68,353	183,505	1,451,629
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC	249,944	19,038			41,583	65,273	375,838
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES	537,924		24,000		52,024	174,729	788,677
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	16,217,785	492,792	24,000	14,494	1,155,455	2,723,102	16,196,352
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		906			1,979		2,885
098	PHYSICIANS' PRIVATE OFFIC	108,900					18,548	127,448
098 01	PROMOTION							
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	16,326,685	493,698	24,000	14,494	1,157,434	2,741,650	16,326,685

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
	6	8	9	10	11	12	14
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG &							
003 02 NEW CAP REL COSTS-BLDG AM							
004 NEW CAP REL COSTS-BLDG EK							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL	2,504,212						
009 OPERATION OF PLANT	234,088	1,526,179					
010 LAUNDRY & LINEN SERVICE	25,459	55,938	221,925				
011 HOUSEKEEPING	77,146	20,475		523,441			
012 DIETARY	58,105	60,600	816	7,533	447,773		
014 CAFETERIA	31,255	29,332		22,050		255,156	
017 NURSING ADMINISTRATION	122,060	23,810				15,120	834,722
018 MEDICAL RECORDS & LIBRARY	62,782	59,918		6,117		14,900	
020 SOCIAL SERVICE	38,122					5,489	45,351
025 NONPHYSICIAN ANESTHETISTS							
026 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	286,890	398,522	142,700	161,240	378,560	53,425	349,857
026 INTENSIVE CARE UNIT	132,522	64,508	4,879	47,752	24,439	24,677	203,361
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	91,972	236,912	11,127	6,802		11,003	37,999
041 ANESTHESIOLOGY	12,367						
044 RADIOLOGY-DIAGNOSTIC	231,214	152,790	5,456	42,502		24,972	
049 LABORATORY	198,387	49,735		37,297		25,976	
050 RESPIRATORY THERAPY	88,647	32,380	3,593	25,428		16,174	
053 PHYSICAL THERAPY	108,301	76,413	4,789	16,480		14,924	
055 ELECTROCARDIOLOGY	47,857		4,294	15,841		5,857	31,982
056 MEDICAL SUPPLIES CHARGED	33,820						
061 DRUGS CHARGED TO PATIENTS	125,637	21,551		2,146		7,425	
062 OUTPAT SERVICE COST CNTRS							
063 EMERGENCY	262,992	148,595	40,828	85,095		23,697	165,889
063 50 OBSERVATION BEDS (NON-DIS							
063 50 OTHER OUTPATIENT SERVICE							
065 RURAL HEALTH CLINIC	68,091	90,397	1,710	20,224		8,013	283
065 OTHER REIMBURS COST CNTRS							
095 AMBULANCE SERVICES	142,885						
096 SPEC PURPOSE COST CENTERS							
098 SUBTOTALS	2,480,599	1,521,876	220,192	496,507	402,999	251,652	834,722
098 01 NONREIMBURS COST CENTERS							
101 GIFT, FLOWER, COFFEE SHOP	523	4,303					
102 PHYSICIANS' PRIVATE OFFIC	23,090		1,733	26,934	44,774	3,504	
103 PROMOTION							
103 01 NONPAID WORKERS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	2,504,212	1,526,179	221,925	523,441	447,773	255,156	834,722

COST ALLOCATION - GENERAL SERVICE COSTS

I
I
I

PROVIDER NO:
14-1323

I PERIOD:
I FROM 4/ 1/2008
I TO 3/31/2009

I PREPARED 8/17/2009
I WORKSHEET B
I PART I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	18	20	25	26	27
003 GENERAL SERVICE COST CNTR						
003 01 NEW CAP REL COSTS-BLDG &						
003 02 NEW CAP REL COSTS-BLDG AM						
004 NEW CAP REL COSTS-MVBLE E						
005 EMPLOYEE BENEFITS						
006 ADMINISTRATIVE & GENERAL						
008 OPERATION OF PLANT						
009 LAUNDRY & LINEN SERVICE						
010 HOUSEKEEPING						
011 DIETARY						
012 CAFETERIA						
014 NURSING ADMINISTRATION						
017 MEDICAL RECORDS & LIBRARY	490,251					
018 SOCIAL SERVICE		299,382				
020 NONPHYSICIAN ANESTHETISTS						
025 INPAT ROUTINE SRVC CNTRS						
026 ADULTS & PEDIATRICS	196,729	261,808		3,813,320	-10,942	3,802,378
026 INTENSIVE CARE UNIT	32,846	35,150		1,301,610	-15,777	1,285,833
026 ANCILLARY SRVC COST CNTRS						
037 OPERATING ROOM	11,531			915,004		915,004
040 ANESTHESIOLOGY				80,627		80,627
041 RADIOLOGY-DIAGNOSTIC				1,733,160		1,733,160
044 LABORATORY	64,645			1,471,071	27,846	1,498,917
049 RESPIRATORY THERAPY	64,645			720,172		720,172
050 PHYSICAL THERAPY				818,691		818,691
053 ELECTROCARDIOLOGY				369,986		369,986
055 MEDICAL SUPPLIES CHARGED				220,494		220,494
056 DRUGS CHARGED TO PATIENTS				850,234		850,234
056 OUTPAT SERVICE COST CNTRS						
061 EMERGENCY	119,855	2,424		2,301,004	-1,126	2,299,878
062 OBSERVATION BEDS (NON-DIS						
063 OTHER OUTPATIENT SERVICE						
063 50 RURAL HEALTH CLINIC				564,556		564,556
063 OTHER REIMBURS COST CNTRS						
065 AMBULANCE SERVICES				931,562		931,562
065 SPEC PURPOSE COST CENTERS						
095 SUBTOTALS	490,251	299,382		16,091,491	1	16,091,492
095 NONREIMBURS COST CENTERS						
096 GIFT, FLOWER, COFFEE SHOP				7,711		7,711
098 PHYSICIANS' PRIVATE OFFIC				227,483		227,483
098 01 PROMOTION						
099 NONPAID WORKERS						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 TOTAL	490,251	299,382		16,326,685	1	16,326,686

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I WORKSHEET B
 I I TO 3/31/2009 I PART III

COST CENTER DESCRIPTION		DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-BLDG AM	NEW CAP REL C OSTS-BLDG EK	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS
		0	3	3.01	3.02	4	4a	5
003	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
003 01	NEW CAP REL COSTS-BLDG AM							
003 02	NEW CAP REL COSTS-BLDG EK							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS		4,101			8,957	13,058	13,058
006	ADMINISTRATIVE & GENERAL		80,034			174,808	254,842	1,869
008	OPERATION OF PLANT		89,593			195,690	285,283	442
009	LAUNDRY & LINEN SERVICE		11,781			25,731	37,512	104
010	HOUSEKEEPING		4,312			9,418	13,730	444
011	DIETARY		12,763			27,876	40,639	245
012	CAFETERIA		6,177			13,492	19,669	195
014	NURSING ADMINISTRATION		5,014			10,952	15,966	828
017	MEDICAL RECORDS & LIBRARY		11,169		1,695	27,562	40,426	355
018	SOCIAL SERVICE							252
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS		83,931			183,320	267,251	1,526
026	INTENSIVE CARE UNIT		13,586			29,674	43,260	876
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM		49,895			108,979	158,874	354
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC		32,178			70,283	102,461	898
044	LABORATORY		10,474			22,878	33,352	719
049	RESPIRATORY THERAPY		6,819			14,895	21,714	477
050	PHYSICAL THERAPY		16,093			35,150	51,243	691
053	ELECTROCARDIOLOGY				12,799	23,917	36,716	211
055	MEDICAL SUPPLIES CHARGED							111
056	DRUGS CHARGED TO PATIENTS		4,539			9,913	14,452	356
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY		31,295			68,353	99,648	874
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC		19,038			41,583	60,621	311
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES			24,000		52,024	76,024	832
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS		492,792	24,000	14,494	1,155,455	1,686,741	12,970
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		906			1,979	2,885	
098	PHYSICIANS' PRIVATE OFFIC							88
098 01	PROMOTION							
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL		493,698	24,000	14,494	1,157,434	1,689,626	13,058

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I WORKSHEET B
 I I TO 3/31/2009 I PART III

COST CENTER DESCRIPTION		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
		6	8	9	10	11	12	14
003	GENERAL SERVICE COST CNTR							
003	01 NEW CAP REL COSTS-BLDG &							
003	02 NEW CAP REL COSTS-BLDG AM							
004	02 NEW CAP REL COSTS-BLDG EK							
005	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL	256,711						
008	OPERATION OF PLANT	23,997	309,722					
009	LAUNDRY & LINEN SERVICE	2,610	11,352	51,578				
010	HOUSEKEEPING	7,908	4,155		26,237			
011	DIETARY	5,956	12,298	190	378	59,706		
012	CAFETERIA	3,204	5,953		1,105		30,126	
014	NURSING ADMINISTRATION	12,513	4,832				1,785	35,924
017	MEDICAL RECORDS & LIBRARY	6,436	12,160		307		1,759	
018	SOCIAL SERVICE	3,908					648	1,952
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	29,410	80,877	33,165	8,081	50,477	6,307	15,058
026	INTENSIVE CARE UNIT	13,585	13,091	1,134	2,394	3,259	2,914	8,752
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	9,428	48,079	2,586	341		1,299	1,635
040	ANESTHESIOLOGY	1,268						
041	RADIOLOGY-DIAGNOSTIC	23,702	31,007	1,268	2,130		2,948	
044	LABORATORY	20,337	10,093		1,869		3,067	
049	RESPIRATORY THERAPY	9,087	6,571	835	1,275		1,910	
050	PHYSICAL THERAPY	11,102	15,507	1,113	826		1,762	
053	ELECTROCARDIOLOGY	4,906		998	794		692	1,376
055	MEDICAL SUPPLIES CHARGED	3,467						
056	DRUGS CHARGED TO PATIENTS	12,879	4,373		108		877	
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	26,960	30,156	9,489	4,265		2,798	7,139
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063	50 RURAL HEALTH CLINIC	6,980	18,345	397	1,014		946	12
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES	14,647						
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	254,290	308,849	51,175	24,887	53,736	29,712	35,924
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP	54	873					
098	PHYSICIANS' PRIVATE OFFIC	2,367		403	1,350	5,970	414	
098	01 PROMOTION							
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	256,711	309,722	51,578	26,237	59,706	30,126	35,924

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	18	20	25	26	27
003 GENERAL SERVICE COST CNTR						
003 01 NEW CAP REL COSTS-BLDG &						
003 02 NEW CAP REL COSTS-BLDG AM						
004 NEW CAP REL COSTS-MVBLE E						
005 EMPLOYEE BENEFITS						
006 ADMINISTRATIVE & GENERAL						
008 OPERATION OF PLANT						
009 LAUNDRY & LINEN SERVICE						
010 HOUSEKEEPING						
011 DIETARY						
012 CAFETERIA						
014 NURSING ADMINISTRATION						
017 MEDICAL RECORDS & LIBRARY	61,443					
018 SOCIAL SERVICE		6,760				
020 NONPHYSICIAN ANESTHETISTS						
025 INPAT ROUTINE SRVC CNTRS						
026 ADULTS & PEDIATRICS	24,656	5,911		522,719		522,719
026 INTENSIVE CARE UNIT	4,117	794		94,176		94,176
026 ANCILLARY SRVC COST CNTRS						
037 OPERATING ROOM	1,445			224,041		224,041
040 ANESTHESIOLOGY				1,268		1,268
041 RADIOLOGY-DIAGNOSTIC				164,414		164,414
044 LABORATORY	8,102			77,539		77,539
049 RESPIRATORY THERAPY	8,102			49,971		49,971
050 PHYSICAL THERAPY				82,244		82,244
053 ELECTROCARDIOLOGY				45,693		45,693
055 MEDICAL SUPPLIES CHARGED				3,578		3,578
056 DRUGS CHARGED TO PATIENTS				33,045		33,045
061 OUTPAT SERVICE COST CNTRS						
061 EMERGENCY	15,021	55		196,405		196,405
062 OBSERVATION BEDS (NON-DIS						
063 OTHER OUTPATIENT SERVICE						
063 50 RURAL HEALTH CLINIC				88,626		88,626
065 OTHER REIMBURS COST CNTRS						
065 AMBULANCE SERVICES				91,503		91,503
095 SPEC PURPOSE COST CENTERS						
095 SUBTOTALS	61,443	6,760		1,675,222		1,675,222
096 NONREIMBURS COST CENTERS						
096 GIFT, FLOWER, COFFEE SHOP				3,812		3,812
098 PHYSICIANS' PRIVATE OFFIC				10,592		10,592
098 01 PROMOTION						
099 NONPAID WORKERS						
101 CROSS FOOT ADJUSTMENTS						
102 NEGATIVE COST CENTER						
103 TOTAL	61,443	6,760		1,689,626		1,689,626

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I WORKSHEET B-1
 I I TO 3/31/2009 I

COST CENTER DESCRIPTION	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION			
	OSTS-BLDG &	OSTS-BLDG AM	OSTS-BLDG EK	OSTS-MVBLE E	FITS	
	(SQUARE FEET	(SQUARE FEET	(SQUARE FEET	(SQUARE FEET	(GROSS SALARIES)	
	3	3.01	3.02	4	5	6a.00
GENERAL SERVICE COST						
003 NEW CAP REL COSTS-BLD	65,375					
003 01 NEW CAP REL COSTS-BLD		3,154				
003 02 NEW CAP REL COSTS-BLD			1,642			
004 NEW CAP REL COSTS-MVB				70,171		
005 EMPLOYEE BENEFITS	543			543	7,418,525	
006 ADMINISTRATIVE & GENE	10,598			10,598	1,061,866	-2,504,212
008 OPERATION OF PLANT	11,864			11,864	251,003	
009 LAUNDRY & LINEN SERVI	1,560			1,560	58,808	
010 HOUSEKEEPING	571			571	252,089	
011 DIETARY	1,690			1,690	138,973	
012 CAFETERIA	818			818	110,529	
014 NURSING ADMINISTRATIO	664			664	470,711	
017 MEDICAL RECORDS & LIB	1,479		192	1,671	201,846	
018 SOCIAL SERVICE					143,262	
020 NONPHYSICIAN ANESTHET						
025 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS	11,114			11,114	867,313	
INTENSIVE CARE UNIT	1,799			1,799	497,759	
037 ANCILLARY SRVC COST C						
040 OPERATING ROOM	6,607			6,607	200,862	
041 ANESTHESIOLOGY						
044 RADIOLOGY-DIAGNOSTIC	4,261			4,261	510,126	
049 LABORATORY	1,387			1,387	408,734	
050 RESPIRATORY THERAPY	903			903	270,989	
053 PHYSICAL THERAPY	2,131			2,131	392,392	
055 ELECTROCARDIOLOGY			1,450	1,450	120,008	
056 MEDICAL SUPPLIES CHAR	601			601	62,789	
DRUGS CHARGED TO PATI					202,325	
061 OUTPAT SERVICE COST C						
062 EMERGENCY	4,144			4,144	496,540	
063 OBSERVATION BEDS (NON						
063 50 OTHER OUTPATIENT SERV	2,521			2,521	176,621	
065 OTHER REIMBURS COST C						
065 AMBULANCE SERVICES		3,154		3,154	472,792	
095 SPEC PURPOSE COST CEN						
095 SUBTOTALS	65,255	3,154	1,642	70,051	7,368,337	-2,504,212
096 NONREIMBURS COST CENT						
098 GIFT, FLOWER, COFFEE	120			120		
098 01 PHYSICIANS' PRIVATE O					50,188	
099 PROMOTION						
101 NONPAID WORKERS						
102 CROSS FOOT ADJUSTMENT						
103 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	493,698	24,000	14,494	1,157,434	2,741,650	
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	7.551786		8.827040		.369568	
(WRKSHT B, PT I)						
105 COST TO BE ALLOCATED		7.609385		16.494478		
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED					13,058	
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER					.001760	
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I WORKSHEET B-1
 I I TO 3/31/2009 I

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
	(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	(TIME SPENT)	(MEALS SERVED)	(FTE)	(NURSING FTES)
	6	8	9	10	11	12	14
GENERAL SERVICE COST							
003 NEW CAP REL COSTS-BLD							
003 01 NEW CAP REL COSTS-BLD							
003 02 NEW CAP REL COSTS-BLD							
004 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENE	13,822,473						
008 OPERATION OF PLANT	1,292,091	42,562					
009 LAUNDRY & LINEN SERVI	140,528	1,560	143,784				
010 HOUSEKEEPING	425,820	571		57,330			
011 DIETARY	320,719	1,690	529	825	27,392		
012 CAFETERIA	172,519	818		2,415		10,412	
014 NURSING ADMINISTRATIO	673,732	664				617	85,606
017 MEDICAL RECORDS & LIB	346,534	1,671		670		608	
018 SOCIAL SERVICE	210,420					224	4,651
020 NONPHYSICIAN ANESTHET							
025 INPAT ROUTINE SRVC CN							
026 ADULTS & PEDIATRICS	1,583,589	11,114	92,454	17,660	23,158	2,180	35,880
INTENSIVE CARE UNIT	731,476	1,799	3,161	5,230	1,495	1,007	20,856
ANCILLARY SRVC COST C							
037 OPERATING ROOM	507,658	6,607	7,209	745		449	3,897
040 ANESTHESIOLOGY	68,260						
041 RADIOLOGY-DIAGNOSTIC	1,276,226	4,261	3,535	4,655		1,019	
044 LABORATORY	1,095,031	1,387		4,085		1,060	
049 RESPIRATORY THERAPY	489,305	903	2,328	2,785		660	
050 PHYSICAL THERAPY	597,784	2,131	3,103	1,805		609	
053 ELECTROCARDIOLOGY	264,155		2,782	1,735		239	3,280
055 MEDICAL SUPPLIES CHAR	186,674						
056 DRUGS CHARGED TO PATI	693,475	601		235		303	
OUTPAT SERVICE COST C							
061 EMERGENCY	1,451,629	4,144	26,452	9,320		967	17,013
062 OBSERVATION BEDS (NON							
063 OTHER OUTPATIENT SERV							
063 50 RURAL HEALTH CLINIC	375,838	2,521	1,108	2,215		327	29
065 OTHER REIMBURS COST C							
AMBULANCE SERVICES	788,677						
095 SPEC PURPOSE COST CEN							
SUBTOTALS	13,692,140	42,442	142,661	54,380	24,653	10,269	85,606
096 NONREIMBURS COST CENT							
098 GIFT, FLOWER, COFFEE	2,885	120					
098 PHYSICIANS' PRIVATE O	127,448		1,123	2,950	2,739	143	
098 01 PROMOTION							
099 NONPAID WORKERS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	2,504,212	1,526,179	221,925	523,441	447,773	255,156	834,722
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER		35.857784		9.130316		24.505955	
(WRKSHT B, PT I)	.181170		1.543461		16.346853		9.750742
105 COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
(WRKSHT B, PT II)							
107 COST TO BE ALLOCATED	256,711	309,722	51,578	26,237	59,706	30,126	35,924
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER		7.276961		.457649		2.893392	
(WRKSHT B, PT III)	.018572		.358719		2.179688		.419643

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I WORKSHEET B-1
 I I TO 3/31/2009 I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS
	(TIME SPENT	(ASSIGNEDTI)IMES	(ASSIGNED) TIME)
	17	18	20
003 GENERAL SERVICE COST			
003 01 NEW CAP REL COSTS-BLD			
003 02 NEW CAP REL COSTS-BLD			
004 NEW CAP REL COSTS-MVB			
005 EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENE			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVI			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATIO			
017 MEDICAL RECORDS & LIB	1,403		
018 SOCIAL SERVICE		247	
020 NONPHYSICIAN ANESTHET			
025 INPAT ROUTINE SRVC CN			
026 ADULTS & PEDIATRICS	563	216	
026 INTENSIVE CARE UNIT	94	29	
037 ANCILLARY SRVC COST C			
040 OPERATING ROOM	33		
041 ANESTHESIOLOGY			
044 RADIOLOGY-DIAGNOSTIC			
049 LABORATORY	185		
050 RESPIRATORY THERAPY	185		
053 PHYSICAL THERAPY			
055 ELECTROCARDIOLOGY			
056 MEDICAL SUPPLIES CHAR			
061 DRUGS CHARGED TO PATI			
062 OUTPAT SERVICE COST C			
063 EMERGENCY	343	2	
063 50 OBSERVATION BEDS (NON			
063 OTHER OUTPATIENT SERV			
063 50 RURAL HEALTH CLINIC			
065 OTHER REIMBURS COST C			
095 AMBULANCE SERVICES			
095 SPEC PURPOSE COST CEN			
095 SUBTOTALS	1,403	247	
096 NONREIMBURS COST CENT			
098 GIFT, FLOWER, COFFEE			
098 01 PHYSICIANS' PRIVATE O			
099 PROMOTION			
101 NONPAID WORKERS			
102 CROSS FOOT ADJUSTMENT			
103 NEGATIVE COST CENTER			
103 COST TO BE ALLOCATED	490,251	299,382	
104 (PER WRKSHT B, PART			
104 UNIT COST MULTIPLIER		1,212.072874	
104 (WRKSHT B, PT I)	349.430506		
105 COST TO BE ALLOCATED			
106 (PER WRKSHT B, PART			
106 UNIT COST MULTIPLIER			
106 (WRKSHT B, PT II)			
107 COST TO BE ALLOCATED	61,443	6,760	
107 (PER WRKSHT B, PART			
108 UNIT COST MULTIPLIER		27.368421	
108 (WRKSHT B, PT III)	43.794013		

POST STEP DOWN ADJUSTMENTS

I PROVIDER NO:
I 14-1323
I

I PERIOD:
I FROM 4/ 1/2008 I PREPARED 8/17/2009
I TO 3/31/2009 I WORKSHEET B-2

DESCRIPTION	WORKSHEET		AMOUNT
	PART	LINE NO.	
1	2	3	4
1 ADJ FOR EPO COSTS IN RENAL DIA	1	57	
2 ADJ FOR EPO COSTS IN HOME PROG	1	64	
3 ADJ FOR ARANESP IN RENAL DIALY	1	57	
4 ADJ FOR ARANESP IN HOME PROGRA	1	64	
5 BLOOD ADMINISTRATION	1	44	27,846
6 BLOOD ADMINISTRATION	1	25	-10,942
7 BLOOD ADMINISTRATION	1	61	-1,126
8 BLOOD ADMINISTRATION	1	26	-15,777

COMPUTATION OF RATIO OF COSTS TO CHARGES

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	3,802,378		3,802,378		
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	1,285,833		1,285,833		
37	OPERATING ROOM	915,004		915,004		
40	ANESTHESIOLOGY	80,627		80,627		
41	RADIOLOGY-DIAGNOSTIC	1,733,160		1,733,160		
44	LABORATORY	1,498,917		1,498,917		
49	RESPIRATORY THERAPY	720,172		720,172		
50	PHYSICAL THERAPY	818,691		818,691		
53	ELECTROCARDIOLOGY	369,986		369,986		
55	MEDICAL SUPPLIES CHARGED	220,494		220,494		
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	850,234		850,234		
61	EMERGENCY	2,299,878		2,299,878		
62	OBSERVATION BEDS (NON-DIS	409,156		409,156		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	564,556		564,556		
65	AMBULANCE SERVICES	931,562		931,562		
101	SUBTOTAL	16,500,648		16,500,648		
102	LESS OBSERVATION BEDS	409,156		409,156		
103	TOTAL	16,091,492		16,091,492		

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,068,447		2,068,447			
26	INTENSIVE CARE UNIT	494,638		494,638			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	57,812	2,290,131	2,347,943	.389705	.389705	
40	ANESTHESIOLOGY	5,598	69,159	74,757	1.078521	1.078521	
41	RADIOLOGY-DIAGNOSTIC	1,062,350	9,574,120	10,636,470	.162945	.162945	
44	LABORATORY	1,560,217	4,980,341	6,540,558	.229173	.229173	
49	RESPIRATORY THERAPY	439,120	284,754	723,874	.994886	.994886	
50	PHYSICAL THERAPY	119,872	692,762	812,634	1.007454	1.007454	
53	ELECTROCARDIOLOGY	330,493	1,139,432	1,469,925	.251704	.251704	
55	MEDICAL SUPPLIES CHARGED	30,813	124,174	154,987	1.422661	1.422661	
56	DRUGS CHARGED TO PATIENTS	1,526,907	801,187	2,328,094	.365206	.365206	
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	77,050	2,995,843	3,072,893	.748441	.748441	
62	OBSERVATION BEDS (NON-DIS	14,894	206,829	221,723	1.845348	1.845348	
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC		408,107	408,107	1.383353	1.383353	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	56,013	1,412,518	1,468,531	.634350	.634350	
101	SUBTOTAL	7,844,224	24,979,357	32,823,581			
102	LESS OBSERVATION BEDS						
103	TOTAL	7,844,224	24,979,357	32,823,581			

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
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,802,378		3,802,378		
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	1,285,833		1,285,833		
37	OPERATING ROOM	915,004		915,004		
40	ANESTHESIOLOGY	80,627		80,627		
41	RADIOLOGY-DIAGNOSTIC	1,733,160		1,733,160		
44	LABORATORY	1,498,917		1,498,917		
49	RESPIRATORY THERAPY	720,172		720,172		
50	PHYSICAL THERAPY	818,691		818,691		
53	ELECTROCARDIOLOGY	369,986		369,986		
55	MEDICAL SUPPLIES CHARGED	220,494		220,494		
56	DRUGS CHARGED TO PATIENTS	850,234		850,234		
61	OUTPAT SERVICE COST CNTRS EMERGENCY	2,299,878		2,299,878		
62	OBSERVATION BEDS (NON-DIS	409,156		409,156		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	564,556		564,556		
65	AMBULANCE SERVICES	931,562		931,562		
101	SUBTOTAL	16,500,648		16,500,648		
102	LESS OBSERVATION BEDS	409,156		409,156		
103	TOTAL	16,091,492		16,091,492		

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	2,068,447		2,068,447			
26	INTENSIVE CARE UNIT	494,638		494,638			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	57,812	2,290,131	2,347,943	.389705	.389705	
40	ANESTHESIOLOGY	5,598	69,159	74,757	1.078521	1.078521	
41	RADIOLOGY-DIAGNOSTIC	1,062,350	9,574,120	10,636,470	.162945	.162945	
44	LABORATORY	1,560,217	4,980,341	6,540,558	.229173	.229173	
49	RESPIRATORY THERAPY	439,120	284,754	723,874	.994886	.994886	
50	PHYSICAL THERAPY	119,872	692,762	812,634	1.007454	1.007454	
53	ELECTROCARDIOLOGY	330,493	1,139,432	1,469,925	.251704	.251704	
55	MEDICAL SUPPLIES CHARGED	30,813	124,174	154,987	1.422661	1.422661	
56	DRUGS CHARGED TO PATIENTS	1,526,907	801,187	2,328,094	.365206	.365206	
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	77,050	2,995,843	3,072,893	.748441	.748441	
62	OBSERVATION BEDS (NON-DIS	14,894	206,829	221,723	1.845348	1.845348	
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC		408,107	408,107	1.383353	1.383353	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	56,013	1,412,518	1,468,531	.634350	.634350	
101	SUBTOTAL	7,844,224	24,979,357	32,823,581			
102	LESS OBSERVATION BEDS						
103	TOTAL	7,844,224	24,979,357	32,823,581			

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	915,004	224,041	690,963			915,004
40	ANESTHESIOLOGY	80,627	1,268	79,359			80,627
41	RADIOLOGY-DIAGNOSTIC	1,733,160	164,414	1,568,746			1,733,160
44	LABORATORY	1,498,917	77,539	1,421,378			1,498,917
49	RESPIRATORY THERAPY	720,172	49,971	670,201			720,172
50	PHYSICAL THERAPY	818,691	82,244	736,447			818,691
53	ELECTROCARDIOLOGY	369,986	45,693	324,293			369,986
55	MEDICAL SUPPLIES CHARGED	220,494	3,578	216,916			220,494
56	DRUGS CHARGED TO PATIENTS	850,234	33,045	817,189			850,234
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,299,878	196,405	2,103,473			2,299,878
62	OBSERVATION BEDS (NON-DIS	409,156		409,156			409,156
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	564,556	88,626	475,930			564,556
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	931,562	91,503	840,059			931,562
101	SUBTOTAL	11,412,437	1,058,327	10,354,110			11,412,437
102	LESS OBSERVATION BEDS	409,156		409,156			409,156
103	TOTAL	11,003,281	1,058,327	9,944,954			11,003,281

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	2,347,943	.389705	.389705
40	ANESTHESIOLOGY	74,757	1.078521	1.078521
41	RADIOLOGY-DIAGNOSTIC	10,636,470	.162945	.162945
44	LABORATORY	6,540,558	.229173	.229173
49	RESPIRATORY THERAPY	723,874	.994886	.994886
50	PHYSICAL THERAPY	812,634	1.007454	1.007454
53	ELECTROCARDIOLOGY	1,469,925	.251704	.251704
55	MEDICAL SUPPLIES CHARGED	154,987	1.422661	1.422661
56	DRUGS CHARGED TO PATIENTS	2,328,094	.365206	.365206
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	3,072,893	.748441	.748441
62	OBSERVATION BEDS (NON-DIS	221,723	1.845348	1.845348
63	OTHER OUTPATIENT SERVICE			
63 50	RURAL HEALTH CLINIC	408,107	1.383353	1.383353
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,468,531	.634350	.634350
101	SUBTOTAL	30,260,496		
102	LESS OBSERVATION BEDS	221,723		
103	TOTAL	30,038,773		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST	CAPITAL COST	OPERATING	CAPITAL	OPERATING COST	COST NET OF
		WKST B, PT I COL. 27 1	WKST B PT II & III, COL. 27 2	COST NET OF CAPITAL COST 3	REDUCTION 4	REDUCTION AMOUNT 5	CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	915,004	224,041	690,963			915,004
40	ANESTHESIOLOGY	80,627	1,268	79,359			80,627
41	RADIOLOGY-DIAGNOSTIC	1,733,160	164,414	1,568,746			1,733,160
44	LABORATORY	1,498,917	77,539	1,421,378			1,498,917
49	RESPIRATORY THERAPY	720,172	49,971	670,201			720,172
50	PHYSICAL THERAPY	818,691	82,244	736,447			818,691
53	ELECTROCARDIOLOGY	369,986	45,693	324,293			369,986
55	MEDICAL SUPPLIES CHARGED	220,494	3,578	216,916			220,494
56	DRUGS CHARGED TO PATIENTS	850,234	33,045	817,189			850,234
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,299,878	196,405	2,103,473			2,299,878
62	OBSERVATION BEDS (NON-DIS	409,156		409,156			409,156
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	564,556	88,626	475,930			564,556
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	931,562	91,503	840,059			931,562
101	SUBTOTAL	11,412,437	1,058,327	10,354,110			11,412,437
102	LESS OBSERVATION BEDS	409,156		409,156			409,156
103	TOTAL	11,003,281	1,058,327	9,944,954			11,003,281

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	2,347,943	.389705	.389705
40	ANESTHESIOLOGY	74,757	1.078521	1.078521
41	RADIOLOGY-DIAGNOSTIC	10,636,470	.162945	.162945
44	LABORATORY	6,540,558	.229173	.229173
49	RESPIRATORY THERAPY	723,874	.994886	.994886
50	PHYSICAL THERAPY	812,634	1.007454	1.007454
53	ELECTROCARDIOLOGY	1,469,925	.251704	.251704
55	MEDICAL SUPPLIES CHARGED	154,987	1.422661	1.422661
56	DRUGS CHARGED TO PATIENTS	2,328,094	.365206	.365206
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	3,072,893	.748441	.748441
62	OBSERVATION BEDS (NON-DIS	221,723	1.845348	1.845348
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	408,107	1.383353	1.383353
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,468,531	.634350	.634350
101	SUBTOTAL	30,260,496		
102	LESS OBSERVATION BEDS	221,723		
103	TOTAL	30,038,773		

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	915,004	2,347,943			
40	ANESTHESIOLOGY	80,627	74,757			
41	RADIOLOGY-DIAGNOSTIC	1,733,160	10,636,470			
44	LABORATORY	1,498,917	6,540,558			
49	RESPIRATORY THERAPY	720,172	723,874			
50	PHYSICAL THERAPY	818,691	812,634			
53	ELECTROCARDIOLOGY	369,986	1,469,925			
55	MEDICAL SUPPLIES CHARGED	220,494	154,987			
56	DRUGS CHARGED TO PATIENTS	850,234	2,328,094			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	2,299,878	3,072,893			
62	OBSERVATION BEDS (NON-DIS	409,156	221,723			
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	564,556	408,107			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	931,562	1,468,531			
101	TOTAL	11,412,437	30,260,496			

COMPUTATION OF OUTPATIENT COST PER VISIT -
 RURAL PRIMARY CARE HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM	915,004		915,004	2,347,943			
40	ANESTHESIOLOGY	80,627		80,627	74,757			
41	RADIOLOGY-DIAGNOSTIC	1,733,160		1,733,160	10,636,470			
44	LABORATORY	1,498,917		1,498,917	6,540,558			
49	RESPIRATORY THERAPY	720,172		720,172	723,874			
50	PHYSICAL THERAPY	818,691		818,691	812,634			
53	ELECTROCARDIOLOGY	369,986	73,558	443,544	1,469,925			
55	MEDICAL SUPPLIES CHARGED	220,494		220,494	154,987			
56	DRUGS CHARGED TO PATIENTS	850,234		850,234	2,328,094			
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY	2,299,878	646,711	2,946,589	3,072,893			
62	OBSERVATION BEDS (NON-DIS	409,156		409,156	221,723			
63	OTHER OUTPATIENT SERVICE							
63	50 RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES	931,562		931,562	1,468,531			
101	TOTAL	10,847,881	720,269	11,568,150	29,852,389			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

TITLE XVIII, PART B

HOSPITAL

		Cost/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
Cost Center Description		1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.389705		.389705		
40	ANESTHESIOLOGY	1.078521		1.078521		
41	RADIOLOGY-DIAGNOSTIC	.162945		.162945		
44	LABORATORY	.229173		.229173		
49	RESPIRATORY THERAPY	.994886		.994886		
50	PHYSICAL THERAPY	1.007454		1.007454		
53	ELECTROCARDIOLOGY	.251704		.251704		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.422661		1.422661		
56	DRUGS CHARGED TO PATIENTS	.365206		.365206		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.748441		.748441		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.845348		1.845348		
63	OTHER OUTPATIENT SERVICE COST CENTER					
63	50 RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	.634350		.634350		
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104	NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		1,029,008			
40 ANESTHESIOLOGY		10,900			
41 RADIOLOGY-DIAGNOSTIC		3,312,329			
44 LABORATORY		1,725,855			
49 RESPIRATORY THERAPY		133,726			
50 PHYSICAL THERAPY		203,355			
53 ELECTROCARDIOLOGY		488,346			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		72,349			
56 DRUGS CHARGED TO PATIENTS		411,972			
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY		845,117			
62 OBSERVATION BEDS (NON-DISTINCT PART)		127,475			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		8,360,432			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		8,360,432			

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

TITLE XVIII, PART B

HOSPITAL

	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description	9	10	11
(A) 37 ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	401,010		
40 ANESTHESIOLOGY	11,756		
41 RADIOLOGY-DIAGNOSTIC	539,727		
44 LABORATORY	395,519		
49 RESPIRATORY THERAPY	133,042		
50 PHYSICAL THERAPY	204,871		
53 ELECTROCARDIOLOGY	122,919		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	102,928		
56 DRUGS CHARGED TO PATIENTS	150,455		
61 OUTPAT SERVICE COST CNTRS			
61 EMERGENCY	632,520		
62 OBSERVATION BEDS (NON-DISTINCT PART)	235,236		
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
65 OTHER REIMBURS COST CNTRS			
65 AMBULANCE SERVICES			
101 SUBTOTAL	2,929,983		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	2,929,983		

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

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,998
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,399
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,399
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	412
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)	133
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	41
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)	13
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,200
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	371
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)	124
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	100.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,802,378
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	4,100
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	1,300
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	530,082
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,272,296

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,895,807
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,895,807
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.726070
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	557.75
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	3,272,296

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 962.72
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 2,117,984
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 2,117,984

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	1,285,833	495	2,597.64	335	870,209
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1,083,585
49 TOTAL PROGRAM INPATIENT COSTS					4,071,778

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
 52 TOTAL PROGRAM EXCLUDABLE COST
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN
 ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS) 357,169
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS) 119,377
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 476,546
 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE
 COST REPORTING PERIOD
 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE
 COST REPORTING PERIOD
 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XVIII PART A HOSPITAL OTHER

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BED DAYS 425
 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 962.72
 85 OBSERVATION BED COST 409,156

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,998
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,399
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,399
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	412
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)	133
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	41
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)	13
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	255
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	100.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,802,378
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	4,100
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	1,300
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	530,082
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,272,296

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,895,807
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,895,807
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.726070
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	557.75
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	3,272,296

TITLE XIX - I/P	HOSPITAL	OTHER				
PART II - HOSPITAL AND SUBPROVIDERS ONLY						
1						
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	962.72				
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	245,494				
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	245,494				
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42	NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	1,285,833	495	2,597.64	44	114,296
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					359,790

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

COMPUTATION OF INPATIENT OPERATING COST

TITLE XIX - I/P 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 425
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 962.72
- 85 OBSERVATION BED COST 409,156

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

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		1,362,490	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		334,000	
37	OPERATING ROOM	.389705	33,979	13,242
40	ANESTHESIOLOGY	1.078521		
41	RADIOLOGY-DIAGNOSTIC	.162945	554,932	90,423
44	LABORATORY	.229173	958,227	219,600
49	RESPIRATORY THERAPY	.994886	282,161	280,718
50	PHYSICAL THERAPY	1.007454	38,332	38,618
53	ELECTROCARDIOLOGY	.251704	209,850	52,820
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.422661	21,939	31,212
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.365206	972,380	355,119
61	EMERGENCY	.748441	2,449	1,833
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.845348		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		3,074,249	1,083,585
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,074,249	

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			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.389705		
40	ANESTHESIOLOGY	1.078521		
41	RADIOLOGY-DIAGNOSTIC	.162945	36,810	5,998
44	LABORATORY	.229173	92,040	21,093
49	RESPIRATORY THERAPY	.994886	30,788	30,631
50	PHYSICAL THERAPY	1.007454	62,596	63,063
53	ELECTROCARDIOLOGY	.251704	7,113	1,790
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.422661	1,633	2,323
56	DRUGS CHARGED TO PATIENTS	.365206	142,058	51,880
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.748441		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.845348		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		373,038	176,778
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		373,038	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	8/17/2009
I	14-1323	I	FROM	4/ 1/2008	I	WORKSHEET E
I	COMPONENT NO:	I	TO	3/31/2009	I	PART B
I	14-1323	I			I	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,929,983
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	2,929,983

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)	2,959,283
20.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

21	CAH DEDUCTIBLES	38,197
22.01	CAH ACTUAL BILLED COINSURANCE	1,309,826
23	LINE 22.01 (SEE INSTRUCTIONS)	
24	SUBTOTAL (SEE INSTRUCTIONS)	1,611,260
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	1,611,260
29	PRIMARY PAYER PAYMENTS	494
30	SUBTOTAL	1,610,766

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

31	COMPOSITE RATE ESRD	
32	BAD DEBTS (SEE INSTRUCTIONS)	304,382
33.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	304,382
34.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
35	SUBTOTAL	1,915,148
36	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
37	OTHER ADJUSTMENTS (SPECIFY)	
38.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
39	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
40	SUBTOTAL	1,915,148
41	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
42	INTERIM PAYMENTS	1,330,484
43.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
44	BALANCE DUE PROVIDER/PROGRAM	584,664
45	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)	
46	IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 3/31/2009 I
 I 14-1323 I I

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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		3,165,399		1,251,009
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	3/23/2009	147,900	3/31/2009	79,475
ADJUSTMENTS TO PROVIDER .02	4/ 1/2009	147,900		
ADJUSTMENTS TO PROVIDER .03	4/ 1/2009	147,900		
ADJUSTMENTS TO PROVIDER .04	3/31/2009	109,175		
ADJUSTMENTS TO PROVIDER .05	3/16/2009	31,062		
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		583,937		79,475
4 TOTAL INTERIM PAYMENTS		3,749,336		1,330,484
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		83,031		584,664
7 TOTAL MEDICARE PROGRAM LIABILITY		3,832,367		1,915,148

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.

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	8/17/2009	
I	14-1323	I	FROM	I	4/ 1/2008	I	WORKSHEET E-1
I	COMPONENT NO:	I	TO	I	3/31/2009	I	
I	14-Z323	I		I		I	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		556,249		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	3/16/2009	14,762		
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		-14,762		NONE
4 TOTAL INTERIM PAYMENTS		541,487		
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)		114,570		
7 TOTAL MEDICARE PROGRAM LIABILITY		656,057		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I
 I COMPONENT NO: I TO 3/31/2009 I WORKSHEET E-2
 I 14-Z323 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	481,311	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	178,546	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	495	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	659,857	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	659,857	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	659,857	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	3,800	
14	80% OF PART B COSTS		
15	SUBTOTAL	656,057	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	656,057	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	541,487	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	114,570	
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	8/17/2009
I	14-1323	I	FROM	4/ 1/2008	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO	3/31/2009	I	PART II
I	14-1323	I			I	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	4,071,778
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	4,071,778
5	PRIMARY PAYER PAYMENTS	4,188
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	4,108,266

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
8	ROUTINE SERVICE CHARGES	
9	ANCILLARY SERVICE CHARGES	
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
11	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	

CUSTOMARY CHARGES

12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	4,108,266
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	386,334
21	EXCESS REASONABLE COST	
22	SUBTOTAL	3,721,932
23	COINSURANCE	8,982
24	SUBTOTAL	3,712,950
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	119,417
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	119,417
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	3,832,367
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	3,832,367
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,749,336
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	83,031
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	5,202,405			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	6,951,404			
5 OTHER RECEIVABLES	41,743			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,739,000			
7 INVENTORY	269,540			
8 PREPAID EXPENSES	222,316			
9 OTHER CURRENT ASSETS	877,957			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	8,826,365			
FIXED ASSETS				
12 LAND	13,981			
12.01 LAND IMPROVEMENTS	1,042,753			
13.01 LESS ACCUMULATED DEPRECIATION	-186,857			
14 BUILDINGS	19,338,159			
14.01 LESS ACCUMULATED DEPRECIATION	-5,641,963			
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	8,749,112			
18.01 LESS ACCUMULATED DEPRECIATION	-5,922,784			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	17,392,401			
OTHER ASSETS				
22 INVESTMENTS	1,760,230			
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	407,925			
26 TOTAL OTHER ASSETS	2,168,155			
27 TOTAL ASSETS	28,386,921			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,732,756			
29 SALARIES, WAGES & FEES PAYABLE	811,502			
30 PAYROLL TAXES PAYABLE	380,027			
31 NOTES AND LOANS PAYABLE (SHORT TERM)	887,329			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	218,919			
36 TOTAL CURRENT LIABILITIES	4,030,533			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	13,591,978			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	13,591,978			
43 TOTAL LIABILITIES	17,622,511			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	10,764,410			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	10,764,410			
52 TOTAL LIABILITIES AND FUND BALANCES	28,386,921			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		10,530,133		
2 NET INCOME (LOSS)		234,277		
3 TOTAL		10,764,410		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		10,764,410		
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		10,764,410		

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

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	1,895,807		1,895,807
4 00 SWING BED - SNF	246,330		246,330
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,142,137		2,142,137
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	494,638		494,638
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	494,638		494,638
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	2,636,775		2,636,775
17 00 ANCILLARY SERVICES	5,271,660	25,496,917	30,768,577
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC		408,107	408,107
20 00 AMBULANCE SERVICES	56,013	1,412,518	1,468,531
24 00			
25 00 TOTAL PATIENT REVENUES	7,964,448	27,317,542	35,281,990

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		17,615,880	
ADD (SPECIFY)			
27 00 BAD DEBT EXPENSE	2,137,466		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		2,137,466	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		19,753,346	

STATEMENT OF REVENUES AND EXPENSES

PROVIDER NO: 14-1323
 I PERIOD: FROM 4/ 1/2008 TO 3/31/2009
 I PREPARED 8/17/2009
 I WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES	35,281,990
2	LESS: ALLOWANCES AND DISCOUNTS ON	15,784,311
3	NET PATIENT REVENUES	19,497,679
4	LESS: TOTAL OPERATING EXPENSES	19,753,346
5	NET INCOME FROM SERVICE TO PATIENT	-255,667
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	117,043
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	12,584
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	71,156
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	2,100
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	24,688
23	GOVERNMENTAL APPROPRIATIONS	173,402
24	GRANTS AND GIFTS	58,843
24.01	EDUCATION SERVICES	3,470
24.02	OTHER MISCELLANEOUS INCOME	37,093
25	TOTAL OTHER INCOME	500,379
26	TOTAL	244,712
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28	SURG PROFESSIONAL SALARIES	10,435
29		
30	TOTAL OTHER EXPENSES	10,435
31	NET INCOME (OR LOSS) FOR THE PERIO	234,277

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

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2	21,836		21,836	
3	93,837		93,837	
4				
5				
6				
7				
8				
9				
10	115,673		115,673	
COSTS UNDER AGREEMENT				
11		40,661	40,661	
12		18,000	18,000	
13				
14		58,661	58,661	
OTHER HEALTH CARE COSTS				
15		13,385	13,385	
16		517	517	
17				
18				
19				
20				
21		13,902	13,902	
22	115,673	72,563	188,236	
COSTS OTHER THAN RHC/FQHC SERVICES				
23				
24				
25				
26				
27				
28				
FACILITY OVERHEAD				
29				
30	60,948	760	61,708	
31	60,948	760	61,708	
32	176,621	73,323	249,944	

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

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
I 14-1323 I FROM 4/ 1/2008 I WORKSHEET M-1
I COMPONENT NO: I TO 3/31/2009 I
I 14-3478 I I

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	21,836		21,836
3 PHYSICIAN ASSISTANT	93,837		93,837
4 NURSE PRACTITIONER			
5 VISITING NURSE			
6 OTHER NURSE			
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN			
10 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	115,673		115,673
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT	40,661		40,661
13 PHYSICIAN SUPERVISION UNDER AGREEMENT	18,000		18,000
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)	58,661		58,661
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	13,385		13,385
17 TRANSPORTATION (HEALTH CARE STAFF)	517		517
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE			
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	13,902		13,902
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	188,236		188,236
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY			
25 DENTAL			
26 OPTOMETRY			
27 ALL OTHER NONREIMBURSABLE COSTS			
28 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	61,708		61,708
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	61,708		61,708
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	249,944		249,944

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
I 14-1323 I FROM 4/ 1/2008 I WORKSHEET M-2
I COMPONENT NO: I TO 3/31/2009 I
I 14-3478 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	.12	693	4,200	504
2	PHYSICIAN ASSISTANTS	1.04	4,183	2,100	2,184
3	NURSE PRACTITIONERS			2,100	
4	SUBTOTAL (SUM OF LINES 1-3)	1.16	4,876		2,688
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.16	4,876		
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)	188,236			
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)	188,236			
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)	61,708			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	314,612			
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	376,320			
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	376,320			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	376,320			
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	564,556			
		GREATER OF COL. 2 OR COL. 4 5			
POSITIONS					
1	PHYSICIANS				
2	PHYSICIAN ASSISTANTS				
3	NURSE PRACTITIONERS				
4	SUBTOTAL (SUM OF LINES 1-3)	4,876			
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4,876			
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.

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I WORKSHEET M-3
 I COMPONENT NO: I TO 3/31/2009 I
 I 14-3478 I I

CALCULATION OF REIMBURSEMENT SETTLEMENT
 FOR RHC/FQHC SERVICES

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	564,556
	(FROM WORKSHEET M-2, LINE 20)	
2	COST OF VACCINES AND THEIR ADMINISTRATION	207
	(FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	564,349
	(LINE 1 MINUS LINE 2)	
4	TOTAL VISITS	4,876
	(FROM WORKSHEET M-2, COLUMN 5, LINE 8)	
5	PHYSICIANS VISITS UNDER AGREEMENT	
	(FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,876
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	115.74

CALCULATION OF LIMIT (1)

	PRIOR TO	ON OR AFTER
	JANUARY 1	JANUARY 1
	1	2

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	76.52	78.82
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	115.74	115.74
CALCULATION OF SETTLEMENT			
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		485
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		56,134
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)*		56,134
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		4,009
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		52,125
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		41,700
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		41,700
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)		41,700
25	INTERIM PAYMENTS		49,504
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		-7,804
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

COMPUTATION OF PNEUMOCOCCAL AND
INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 8/17/2009
 I 14-1323 I FROM 4/ 1/2008 I WORKSHEET M-4
 I COMPONENT NO: I TO 3/31/2009 I
 I 14-3478 I I

TITLE XVIII

RHC 1

	PNEUMOCOCCAL 1	INFLUENZA 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	115,673	115,673
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		.000052
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)		6
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)		63
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		69
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	188,236	188,236
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	376,320	376,320
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		.000367
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)		138
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)		207
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		6
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)		34.50
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)		
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		207
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		

RHC 1

DESCRIPTION	P A R T		B AMOUNT
	MM/DD/YYYY 1	2	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER			51,128
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
ADJUSTMENTS TO PROVIDER			.01
ADJUSTMENTS TO PROVIDER			.02
ADJUSTMENTS TO PROVIDER			.03
ADJUSTMENTS TO PROVIDER			.04
ADJUSTMENTS TO PROVIDER			.05
ADJUSTMENTS TO PROGRAM	3/16/2009		.50
ADJUSTMENTS TO PROGRAM			.51
ADJUSTMENTS TO PROGRAM			.52
ADJUSTMENTS TO PROGRAM			.53
ADJUSTMENTS TO PROGRAM			.54
ADJUSTMENTS TO PROGRAM			.99
SUBTOTAL			-1,624
4 TOTAL INTERIM PAYMENTS			49,504
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
TENTATIVE TO PROVIDER			.01
TENTATIVE TO PROVIDER			.02
TENTATIVE TO PROVIDER			.03
TENTATIVE TO PROGRAM			.50
TENTATIVE TO PROGRAM			.51
TENTATIVE TO PROGRAM			.52
TENTATIVE TO PROGRAM			.99
SUBTOTAL			NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			7,804
7 TOTAL MEDICARE PROGRAM LIABILITY			41,700

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.