

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	14-1329	I	FROM 7/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 6/30/2009	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
	I		I		I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/24/2009 TIME 16:30

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:
 MORRISON COMMUNITY HOSPITAL 14-1329
 FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2008 AND ENDING 6/30/2009 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2	3	4	5	
1	HOSPITAL	0	-2,948	44,994	0	
3	SWING BED - SNF	0	5,435	0	0	
5	HOSPITAL-BASED SNF	0	0	0	0	
9	RHC	0	0	9,284	0	
9 .01	RHC II	0	0	-8,250	0	
100	TOTAL	0	2,487	46,028	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: 303 JACKSON P. O. BOX:
 1.01 CITY: MORRISON STATE: IL ZIP CODE: 61270- COUNTY: WHITESIDE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O OR N)		
					V	XVII	XIX
02.00 HOSPITAL	MORRISON COMMUNITY HOSPITAL	14-1329	2.01	8/1/2003	4	5	6
04.00 SWING BED - SNF	MORRISON SWING BED	14-2329		8/1/2003	N	O	O
06.00 HOSPITAL-BASED SNF	MORRISON SNF	14-5274		8/13/1974	N	P	O
14.00 HOSPITAL-BASED RHC	MORRISON COMMUNITY HOSPITAL CLINIC	14-3981		7/1/1996	N	O	O
14.01 HOSPITAL-BASED RHC 2	MERCY CLINIC OF SAVANNA	14-3481		7/25/2006	N	O	O

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

18 TYPE OF CONTROL 11 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO. N
- 21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER: ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /
- 25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N
- 25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-1, 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. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N
- 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
- 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IIME 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)

FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). N 0

MULTI CAMPUS

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). Y 8/17/2009

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 303 JACKSON
 1.01 CITY: MORRISON STATE: IL ZIP CODE: 61270 COUNTY: WHITESIDE
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	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:

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

FACILITY HOURS OF OPERATIONS (1)

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 333 CHIGAGO AVENUE
 1.01 CITY: SAVANNA STATE: IL ZIP CODE: 61074 COUNTY:
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	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:

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
0 CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14
			830	1700	830	1700	830	1700	830	1700	830	1700		

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

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N
 14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES. N
 15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVII I 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

PROVIDER NO: 14-1329

PERIOD: FROM 7/1/2008 TO 6/30/2009

PREPARED 11/24/2009
WORKSHEET A

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		388,748	388,748	-54,743	334,005
3.01	0301 NEW CAP REL COSTS-BLDG & FIXT					
4	0400 NEW CAP REL COSTS-MVBLE EQUIP				107,062	107,062
5	0500 EMPLOYEE BENEFITS		639,819	639,819		639,819
6.01	0611 PURCHASING	23,143	5,401	28,544		28,544
6.02	0614 PERSONNEL	92,052	46,827	138,879		138,879
6.03	0612 HOSPITAL BILLING	186,895	154,582	341,477		341,477
6.04	0613 NURSING HOME BILLING	1,534	1,284	2,818		2,818
6.05	0660 OTHER ADMINISTRATIVE AND GENERAL	185,850	651,053	836,903	-29,762	807,141
8	0800 OPERATION OF PLANT	77,411	362,613	440,024		440,024
9	0900 LAUNDRY & LINEN SERVICE		50,326	50,326		50,326
10	1000 HOUSEKEEPING	157,619	33,310	190,929		190,929
11	1100 DIETARY	176,129	100,418	276,547		276,547
12	1200 CAFETERIA					
14	1400 NURSING ADMINISTRATION	146,901	3,469	150,370		150,370
15	1500 CENTRAL SERVICES & SUPPLY		61	61		61
17	1700 MEDICAL RECORDS & LIBRARY	157,491	16,556	174,047		174,047
17.01	1702 NURSING HOME MEDICAL RECORDS & LIBRA	6,339	671	7,010		7,010
18	1800 SOCIAL SERVICE	48,502	611	49,113		49,113
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	948,604	101,431	1,050,035	-16,573	1,033,462
34	3400 SKILLED NURSING FACILITY	633,127	43,192	676,319	-7,315	669,004
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	42,787	64,735	107,522	-2,290	105,232
40	4000 ANESTHESIOLOGY		24,974	24,974		24,974
41	4100 RADIOLOGY-DIAGNOSTIC	171,029	61,612	232,641	-4,268	228,373
44	4400 LABORATORY	245,222	201,335	446,557	-93,995	352,562
49	4900 RESPIRATORY THERAPY		35,377	35,377	-25,137	10,240
50	5000 PHYSICAL THERAPY	193,332	5,668	199,000	-19	198,981
51	5100 OCCUPATIONAL THERAPY	99,858	1,927	101,785		101,785
52	5200 SPEECH PATHOLOGY		2,840	2,840		2,840
53	5300 ELECTROCARDIOLOGY	2,942	4,280	7,222		7,222
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		20,868	20,868	172,693	193,561
56	5600 DRUGS CHARGED TO PATIENTS	116,400	198,504	314,904		314,904
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC					
61	6100 EMERGENCY	295,558	524,999	820,557	-16,827	803,730
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	431,913	578,285	1,010,198	14,022	1,024,220
63.51	6311 RURAL HEALTH CLINIC 2	69,527	35,417	104,944		104,944
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES	90,113	52,268	142,381	-5,143	137,238
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		40,390	40,390	-40,390	
90	9000 OTHER CAPITAL RELATED COSTS					
95	SUBTOTALS	4,600,278	4,453,851	9,054,129	-2,685	9,051,444
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
100	7950 RENTAL HOUSE				2,685	2,685
100.01	7951 RENTAL SPACE					
100.02	7952 OTHER NONREIMBURSABLE COST CENTERS					
101	TOTAL	4,600,278	4,453,851	9,054,129	-0-	9,054,129

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I
I 14-1329 I
I I

I PERIOD: I PREPARED 11/24/2009 I
I FROM 7/ 1/2008 I WORKSHEET A I
I TO 6/30/2009 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-35,216	298,789
3.01	0301 NEW CAP REL COSTS-BLDG & FIXT		
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-522	106,540
5	0500 EMPLOYEE BENEFITS	-803	639,016
6.01	0611 PURCHASING		28,544
6.02	0614 PERSONNEL		138,879
6.03	0612 HOSPITAL BILLING		341,477
6.04	0613 NURSING HOME BILLING		2,818
6.05	0660 OTHER ADMINISTRATIVE AND GENERAL	-60,915	746,226
8	0800 OPERATION OF PLANT		440,024
9	0900 LAUNDRY & LINEN SERVICE		50,326
10	1000 HOUSEKEEPING		190,929
11	1100 DIETARY	-16,836	259,711
12	1200 CAFETERIA		
14	1400 NURSING ADMINISTRATION		150,370
15	1500 CENTRAL SERVICES & SUPPLY		61
17	1700 MEDICAL RECORDS & LIBRARY	-3,743	170,304
17.01	1702 NURSING HOME MEDICAL RECORDS & LIBRA		7,010
18	1800 SOCIAL SERVICE		49,113
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-2,154	1,031,308
34	3400 SKILLED NURSING FACILITY		669,004
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		105,232
40	4000 ANESTHESIOLOGY		24,974
41	4100 RADIOLOGY-DIAGNOSTIC	-1,159	227,214
44	4400 LABORATORY	-25,950	326,612
49	4900 RESPIRATORY THERAPY		10,240
50	5000 PHYSICAL THERAPY	-949	198,032
51	5100 OCCUPATIONAL THERAPY		101,785
52	5200 SPEECH PATHOLOGY		2,840
53	5300 ELECTROCARDIOLOGY	-4,280	2,942
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-555	193,006
56	5600 DRUGS CHARGED TO PATIENTS	-27,579	287,325
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		
61	6100 EMERGENCY	-71,185	732,545
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC	-10,989	1,013,231
63.51	6311 RURAL HEALTH CLINIC 2		104,944
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES	-640	136,598
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-263,475	8,787,969
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
100	7950 RENTAL HOUSE		2,685
100.01	7951 RENTAL SPACE		
100.02	7952 OTHER NONREIMBURSABLE COST CENTERS		
101	TOTAL	-263,475	8,790,654

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 11/24/2009
 I 14-1329 I FROM 7/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 6/30/2009 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
3.01	NEW CAP REL COSTS-BLDG & FIXT	0301	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6.01	PURCHASING	0611	NONPATIENT TELEPHONES
6.02	PERSONNEL	0614	NONPATIENT TELEPHONES
6.03	HOSPITAL BILLING	0612	NONPATIENT TELEPHONES
6.04	NURSING HOME BILLING	0613	NONPATIENT TELEPHONES
6.05	OTHER ADMINISTRATIVE AND GENERAL	0660	OTHER ADMINISTRATIVE AND GENERAL
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
17	MEDICAL RECORDS & LIBRARY	1700	
17.01	NURSING HOME MEDICAL RECORDS & LIBRA	1702	MEDICAL RECORDS & LIBRARY
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
34	SKILLED NURSING FACILITY	3400	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
63.51	RURAL HEALTH CLINIC 2	6311	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
100	RENTAL HOUSE	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	RENTAL SPACE	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	OTHER NONREIMBURSABLE COST CENTERS	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:
141329

PERIOD:
FROM 7/ 1/2008
TO 6/30/2009

PREPARED 11/24/2009
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	INCREASE				
	CODE (1)	COST CENTER 2	LINE NO 3	SALARY 4	OTHER 5
1 RECLASSIFY MEDICAL SUPPLIES COST	A	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		172,693
2					
3					
4					
5					
6					
7					
8					
9					
10 RECLASS CT INTEREST EXPENSE	B	RADIOLOGY-DIAGNOSTIC	41		342
11		NEW CAP REL COSTS-BLDG & FIXT	3		36,247
12		ADULTS & PEDIATRICS	25		663
13		OTHER ADMINISTRATIVE AND GENERAL	6.05		3,017
14		LABORATORY	44		121
15 RENTAL HOUSE COSTS	D	RENTAL HOUSE	100		2,685
16		NEW CAP REL COSTS-BLDG & FIXT	3		751
17 RECLASS PROPERTY INSURANCE	F	NEW CAP REL COSTS-BLDG & FIXT	3		8,311
18		OTHER ADMINISTRATIVE AND GENERAL	6.05		11,020
19		NEW CAP REL COSTS-BLDG & FIXT	3		7,010
20		RURAL HEALTH CLINIC	63.50		14,022
21 B&F DEPRECIATION	G	NEW CAP REL COSTS-MVBLE EQUIP	4		107,062
36 TOTAL RECLASSIFICATIONS					363,944

(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:
141329

PERIOD:
FROM 7/1/2008
TO 6/30/2009

PREPARED 11/24/2009
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF 10
			6	LINE NO 7			
1 RECLASSIFY MEDICAL SUPPLIES COST	A	ADULTS & PEDIATRICS		25		17,236	
2		SKILLED NURSING FACILITY		34		7,315	
3		OPERATING ROOM		37		2,290	
4		RADIOLOGY-DIAGNOSTIC		41		4,610	
5		LABORATORY		44		94,116	
6		RESPIRATORY THERAPY		49		25,137	
7		PHYSICAL THERAPY		50		19	
8		EMERGENCY		61		16,827	
9		AMBULANCE SERVICES		65		5,143	
10 RECLASS CT INTEREST EXPENSE	B	INTEREST EXPENSE		88		40,390	11
11							11
12							
13							
14							
15 RENTAL HOUSE COSTS	D	OTHER ADMINISTRATIVE AND GENERAL		6.05		3,436	9
16							9
17 RECLASS PROPERTY INSURANCE	F	OTHER ADMINISTRATIVE AND GENERAL		6.05		40,363	12
18							12
19							12
20							
21 B&F DEPRECIATION	G	NEW CAP REL COSTS-BLDG & FIXT		3		107,062	9
36 TOTAL RECLASSIFICATIONS						363,944	

(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:
141329

PERIOD:
FROM 7/1/2008
TO 6/30/2009

PREPARED 11/24/2009
WORKSHEET A-6
NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION: RECLASSIFY MEDICAL SUPPLIES COST

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	172,693	ADULTS & PEDIATRICS	25	17,236	
2.00			0	SKILLED NURSING FACILITY	34	7,315	
3.00			0	OPERATING ROOM	37	2,290	
4.00			0	RADIOLOGY-DIAGNOSTIC	41	4,610	
5.00			0	LABORATORY	44	94,116	
6.00			0	RESPIRATORY THERAPY	49	25,137	
7.00			0	PHYSICAL THERAPY	50	19	
10.00			0	EMERGENCY	61	16,827	
11.00			0	AMBULANCE SERVICES	65	5,143	
TOTAL RECLASSIFICATIONS FOR CODE A			172,693	TOTAL RECLASSIFICATIONS FOR CODE A			172,693

RECLASS CODE: B
EXPLANATION: RECLASS CT INTEREST EXPENSE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	RADIOLOGY-DIAGNOSTIC	41	342	INTEREST EXPENSE	88	40,390	
2.00	NEW CAP REL COSTS-BLDG & FIXT	3	36,247			0	
3.00	ADULTS & PEDIATRICS	25	663			0	
4.00	OTHER ADMINISTRATIVE AND GENER	6.05	3,017			0	
5.00	LABORATORY	44	121			0	
TOTAL RECLASSIFICATIONS FOR CODE B			40,390	TOTAL RECLASSIFICATIONS FOR CODE B			40,390

RECLASS CODE: D
EXPLANATION: RENTAL HOUSE COSTS

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	RENTAL HOUSE	100	2,685	OTHER ADMINISTRATIVE AND GENER	6.05	3,436	
2.00	NEW CAP REL COSTS-BLDG & FIXT	3	751			0	
TOTAL RECLASSIFICATIONS FOR CODE D			3,436	TOTAL RECLASSIFICATIONS FOR CODE D			3,436

RECLASS CODE: F
EXPLANATION: RECLASS PROPERTY INSURANCE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	8,311	OTHER ADMINISTRATIVE AND GENER	6.05	40,363	
2.00	OTHER ADMINISTRATIVE AND GENER	6.05	11,020			0	
3.00	NEW CAP REL COSTS-BLDG & FIXT	3	7,010			0	
4.00	RURAL HEALTH CLINIC	63.50	14,022			0	
TOTAL RECLASSIFICATIONS FOR CODE F			40,363	TOTAL RECLASSIFICATIONS FOR CODE F			40,363

RECLASS CODE: G
EXPLANATION: B&F DEPRECIATION

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	107,062	NEW CAP REL COSTS-BLDG & FIXT	3	107,062	
TOTAL RECLASSIFICATIONS FOR CODE G			107,062	TOTAL RECLASSIFICATIONS FOR CODE G			107,062

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DI SPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND							
2 LAND IMPROVEMENTS							
3 BUILDINGS & FIXTURE							
4 BUILDING IMPROVEMENT							
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 DONATION 3	TOTAL 4	DI SPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND	21,657					21,657	
2 LAND IMPROVEMENTS	454,954	167,252		167,252		622,206	
3 BUILDINGS & FIXTURE	5,266,362	18,850		18,850		5,285,212	
4 BUILDING IMPROVEMENT							
5 FIXED EQUIPMENT							
6 MOVABLE EQUIPMENT	3,017,925	549,848		549,848		3,567,773	
7 SUBTOTAL	8,760,898	735,950		735,950		9,496,848	
8 RECONCILING ITEMS							
9 TOTAL	8,760,898	735,950		735,950		9,496,848	

PART III - RECONCILIATION OF CAPITAL COST CENTERS
 DESCRIPTION

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL	
DESCRIPTION		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	5,929,075		5,929,075	.624320				
3 01	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV	3,567,773		3,567,773	.375680				
5	TOTAL	9,496,848		9,496,848	1.000000				

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	175,376		1,031	41,138		81,244	298,789
3 01	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV	106,540						106,540
5	TOTAL	281,916		1,031	41,138		81,244	405,329

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

SUMMARY OF OLD AND NEW CAPITAL

		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	281,687			25,817		81,244	388,748
3 01	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV							
5	TOTAL	281,687			25,817		81,244	388,748

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

DESCRPTION (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 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &		3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E		4	
5 INVESTMENT INCOME-OTHER						
6 TRADE, QUANTITY AND TIME DISCOUNTS						
7 REFUNDS AND REBATES OF EXPENSES						
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS						
9 TELEPHONE SERVICES						
10 TELEVISION AND RADIO SERVICE						
11 PARKING LOT						
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-74,255				
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1					
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS						
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS						
18 SALE OF MED AND SURG SUPPLIES						
19 SALE OF DRUGS TO OTHER THAN PATIENTS						
20 SALE OF MEDICAL RECORDS & ABSTRACTS						
21 NURSG SCHOOL(TUITN, FEES, BOOKS, ETC.)						
22 VENDING MACHINES						
23 INCOME FROM IMPOSITION OF INTEREST						
24 INTRST EXP ON MEDICARE OVERPAYMENTS						
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY		49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY		50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3					
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**		89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &		3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E		4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**		20	
34 PHYSICIANS' ASSISTANT						
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY		51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY		52	
37 COPY & TRANSCRIPTS	B	-3,743	MEDICAL RECORDS & LIBRARY		17	
38						
38.02 CAFETERIA SALES-EMPLOYEE	B	-15,315	DIETARY		11	
38.04 TELEVISION EQUIPMENT	A	-522	NEW CAP REL COSTS-MVBLE E		4	9
38.05 LAB OTHER REVENUE	B	-24,442	LABORATORY		44	
38.06 PHARMACY EMPLOYEE REVENUE	B	-25,164	DRUGS CHARGED TO PATIENTS		56	
39 ADVERTISING	A	-45,196	OTHER ADMINISTRATIVE AND		6.05	
40 NONALLOWABLE IHA DUES	A	-3,886	OTHER ADMINISTRATIVE AND		6.05	
41 OTHER REV -A&G	B	-573	OTHER ADMINISTRATIVE AND		6.05	
42 OTHER REV -DIETARY	B	-1,521	DIETARY		11	
43 OTHER REV -PHARMACY	B	-2,059	DRUGS CHARGED TO PATIENTS		56	
44						
45 OTHER REV - AMBULANCE	B	-640	AMBULANCE SERVICES		65	
46						
47 PATIENT TELEPHONE - SALARIES	A	-5,775	OTHER ADMINISTRATIVE AND		6.05	
48 PATIENT TELEPHONE - BENEFITS	A	-803	EMPLOYEE BENEFITS		5	
49 INVESTMENT INCOME-OTHER	B	-317	RADIOLOGY-DIAGNOSTIC		41	
49.01 INVESTMENT INCOME-OTHER	B	-35,216	NEW CAP REL COSTS-BLDG &		3	11
49.02 INVESTMENT INCOME-OTHER	B	-615	ADULTS & PEDIATRICS		25	
49.03 INVESTMENT INCOME-OTHER	B	-2,800	OTHER ADMINISTRATIVE AND		6.05	
49.04 PROPERTY TAXES	A	-2,685	OTHER ADMINISTRATIVE AND		6.05	
49.05						
49.06 INVESTMENT INCOME-OTHER	B	-112	LABORATORY		44	
49.07 IP SELF INSURANCE OFFSET	A	-1,539	ADULTS & PEDIATRICS		25	
49.08 IP SELF INSURANCE OFFSET	A	-51	LABORATORY		44	
49.09 IP SELF INSURANCE OFFSET	A	-247	DRUGS CHARGED TO PATIENTS		56	
49.10 OP SELF INSURANCE OFFSET	A	-842	RADIOLOGY-DIAGNOSTIC		41	
49.11 OP SELF INSURANCE OFFSET	A	-1,345	LABORATORY		44	
49.12 OP SELF INSURANCE OFFSET	A	-949	PHYSICAL THERAPY		50	
49.13 OP SELF INSURANCE OFFSET	A	-555	MEDICAL SUPPLIES CHARGED		55	
49.14 OP SELF INSURANCE OFFSET	A	-109	DRUGS CHARGED TO PATIENTS		56	
49.15 OP SELF INSURANCE OFFSET	A	-1,210	EMERGENCY		61	
49.16 CLINIC SELF INSURANCE OFFSET	A	-10,989	RURAL HEALTH CLINIC		63.50	
50 TOTAL (SUM OF LINES 1 THRU 49)		-263,475				

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(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 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7

PROVIDER BASED PHYSICIAN ADJUSTMENTS

PROVIDER NO:
14-1329

PERIOD:
FROM 7/1/2008
TO 6/30/2009

PREPARED 11/24/2009
WORKSHEET A-8-2
GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	61 ER PHYSICIAN FEES	411,335	69,975	341,360				
2	61 ER MEDICAL DIRECTOR	3,000		3,000				
3	53 EKG PHYSICIAN FEES	4,280	4,280					
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	418,615	74,255	344,360				

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

PROVIDER NO: 14-1329

PERIOD: FROM 7/1/2008 TO 6/30/2009

PREPARED 11/24/2009
WORKSHEET A-8-4
PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

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

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

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

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

PHYSICAL THERAPY

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

- 57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)
- 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)
- 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
- 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)
- 61 EQUIPMENT COST (SEE INSTRUCTIONS)
- 62 SUPPLIES (SEE INSTRUCTIONS)

REASONABLE COST DETERMINATION FOR THERAPY
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PHYSICAL THERAPY

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

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

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

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

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OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	7
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	105
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	8
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.63
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	3.63

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED	21.00			
10	AHSEA (SEE INSTRUCTIONS)	83.07	66.46	49.84	33.23
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	33.23	33.23	24.92	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	1,396
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	1,396
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	1,396

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	66.48
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	6,980
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	6,980

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

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	199
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	199
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	29
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	228
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	

OCCUPATIONAL THERAPY

32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2,
 LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL 228
 EXPENSE (LINE 28)
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL
 EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 6,980
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM
 PART III, LINE 33, 34, OR 35) 228
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES
 (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)

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OCCUPATIONAL THERAPY

63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	7,208
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	1,331
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	1,331
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	1,331
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE WITH LINE 65)	

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

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SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	8
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	120
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	29
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.63
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	3.63

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED	79.83	24.00		
10	AHSEA (SEE INSTRUCTIONS)	31.93	63.86	47.90	31.93
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)		31.93	23.95	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	1,533
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	1,533
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	1,533

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	63.88
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	7,666
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	7,666

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

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	695
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	695
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	105
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	800

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	

SPEECH PATHOLOGY

32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 800
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 7,666
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 800
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)

REASONABLE COST DETERMINATION FOR THERAPY
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SPEECH PATHOLOGY

63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	8,466
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	2,840
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	2,840
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	2,840
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE WITH LINE 65)	

COST ALLOCATION STATISTICS

PROVIDER NO: 14-1329
 PERIOD: FROM 7/1/2008 TO 6/30/2009
 PREPARED 11/24/2009
 NOT A CMS WORKSHEET

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 & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS SALARIES	ENTERED
6.01	PURCHASING	21	PURCHASE ORDERS	ENTERED
6.02	PERSONNEL	S	GROSS SALARIES	ENTERED
6.03	HOSPITAL BILLING	23	NON-NURSING HOME CHARGES	ENTERED
6.04	NURSING HOME BILLING	22	NURSING HOME CHARGES	ENTERED
6.05	OTHER ADMINISTRATIVE AND GENERAL	-6	ACCUM. COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	9	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	3	SQUARE FEET	ENTERED
11	DIETARY	11	MEALS SERVED	ENTERED
12	CAFETERIA	12	FTE'S	ENTERED
14	NURSING ADMINISTRATION	14	COSTED REQUI S.	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED REQUI S.	ENTERED
17	MEDICAL RECORDS & LIBRARY	23	NON-NURSING HOME CHARGES	ENTERED
17.01	NURSING HOME MEDICAL RECORDS & LIBRA	22	NURSING HOME CHARGES	ENTERED
18	SOCIAL SERVICE	18	TIME SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER NO:
14-1329

PERIOD:
FROM 7/ 1/2008
TO 6/30/2009

PREPARED 11/24/2009
WORKSHEET B
PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTs-BLDG & 3	NEW CAP REL C OSTs-BLDG & 3.01	NEW CAP REL C OSTs-MVBLE E FITS 4	EMPLOYEE BENE FITS 5	PURCHASING 6.01	PERSONNEL 6.02
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG &	298,789	298,789					
004 NEW CAP REL COSTS-MVBLE E	106,540			106,540			
005 EMPLOYEE BENEFITS	639,016				639,016		
006 01 PURCHASING	28,544	9,122			3,215	40,881	
006 02 PERSONNEL	138,879	2,901		377	12,787	801	155,745
006 03 HOSPITAL BILLING	341,477	5,009		1,668	25,961	1,851	6,490
006 04 NURSING HOME BILLING	2,818	507			213	175	53
006 05 OTHER ADMINISTRATIVE AND	746,226	15,117		8,961	25,816	2,502	6,454
008 OPERATION OF PLANT	440,024	56,393		779	10,753	1,226	2,688
009 LAUNDRY & LINEN SERVICE	50,326	7,181					
010 HOUSEKEEPING	190,929	2,998			21,895	726	5,473
011 DIETARY	259,711	8,308		242	24,466	1,026	6,116
012 CAFETERIA		3,197					
014 NURSING ADMINISTRATION	150,370	4,243			20,406	200	5,101
015 CENTRAL SERVICES & SUPPLY	61	2,804				25	
017 MEDICAL RECORDS & LIBRARY	170,304	6,599		1,772	21,877	1,601	5,469
017 01 NURSING HOME MEDICAL RECO	7,010	539			881	100	220
018 SOCIAL SERVICE	49,113	825			6,737	75	1,684
025 INPAT ROUTINE SRVC CNTRS							
034 ADULTS & PEDIATRICS	1,031,308	50,468		15,610	131,770	4,629	32,943
034 SKILLED NURSING FACILITY	669,004	47,552		420	87,946	4,303	21,985
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	105,232	9,392		7,919	5,943	1,801	1,486
041 ANESTHESIOLOGY	24,974						
041 RADIOLOGY-DIAGNOSTIC	227,214	7,510		34,453	23,757	1,876	5,939
044 LABORATORY	326,612	7,580		10,832	34,063	4,178	8,515
049 RESPIRATORY THERAPY	10,240						
050 PHYSICAL THERAPY	198,032	7,812		292	26,855	500	6,713
051 OCCUPATIONAL THERAPY	101,785	2,669		4	13,871		3,468
052 SPEECH PATHOLOGY	2,840						
053 ELECTROCARDIOLOGY	2,942				409		102
055 MEDICAL SUPPLIES CHARGED	193,006						
056 DRUGS CHARGED TO PATIENTS	287,325	2,609		3,550	16,169	450	4,042
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	732,545	6,750		1,927	41,055	5,080	10,263
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	1,013,231	15,500		14,343	59,996	4,629	14,998
063 51 RURAL HEALTH CLINIC 2	104,944				9,658		2,414
065 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	136,598	15,204		3,391	12,517	3,127	3,129
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	8,787,969	298,789		106,540	639,016	40,881	155,745
096 NONREIMBURS COST CENTERS							
100 GIFT, FLOWER, COFFEE SHOP							
100 RENTAL HOUSE	2,685						
100 01 RENTAL SPACE							
100 02 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	8,790,654	298,789		106,540	639,016	40,881	155,745

COST CENTER DESCRIPTION	HOSPITAL BILLING	NURSING HOME BILLING	SUBTOTAL	OTHER ADMINISTRATIVE AND	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
	6.03	6.04	6a.04	6.05	8	9	10
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 PURCHASING							
006 02 PERSONNEL							
006 03 HOSPITAL BILLING	382,456						
006 04 NURSING HOME BILLING		3,766					
006 05 OTHER ADMINISTRATIVE AND			805,076	805,076			
008 OPERATION OF PLANT			511,863	51,604	563,467		
009 LAUNDRY & LINEN SERVICE			57,507	5,798	19,293	82,598	
010 HOUSEKEEPING			222,021	22,383	8,053		252,457
011 DIETARY			299,869	30,232	22,320		10,510
012 CAFETERIA			3,197	322	8,589		4,044
014 NURSING ADMINISTRATION			180,320	18,179	11,399		5,368
015 CENTRAL SERVICES & SUPPLY			2,890	291	7,532		3,547
017 MEDICAL RECORDS & LIBRARY			207,622	20,932	17,728		8,348
017 01 NURSING HOME MEDICAL RECO			8,750	882	1,448		682
018 SOCIAL SERVICE			58,434	5,891	2,216		1,044
025 INPAT ROUTINE SRVC CNTRS							
034 ADULTS & PEDIATRICS	47,566		1,314,294	132,503	135,583	20,011	63,845
034 SKILLED NURSING FACILITY		3,766	834,976	84,179	127,748	56,359	60,156
034 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	10,557		142,330	14,349	25,231	123	11,881
040 ANESTHESIOLOGY	2,549		27,523	2,775			
041 RADIOLOGY-DIAGNOSTIC	50,391		351,140	35,401	20,176	1,425	9,501
044 LABORATORY	49,256		441,036	44,463	20,364		9,589
049 RESPIRATORY THERAPY	7,402		17,642	1,779			
050 PHYSICAL THERAPY	34,520		274,724	27,697	20,987	1,398	9,883
051 OCCUPATIONAL THERAPY	17,227		139,024	14,016	7,170		3,376
052 SPEECH PATHOLOGY	462		3,302	333			
053 ELECTROCARDIOLOGY	2,315		5,768	582			
055 MEDICAL SUPPLIES CHARGED	11,956		204,962	20,663			
056 DRUGS CHARGED TO PATIENTS	40,106		354,251	35,714	7,010		3,301
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	18,662		816,282	82,294	18,134	2,408	8,539
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	73,416		1,196,113	120,587	41,641	486	19,609
063 51 RURAL HEALTH CLINIC 2	2,898		119,914	12,089			
063 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	13,173		187,139	18,867	40,845	388	19,234
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	382,456	3,766	8,787,969	804,805	563,467	82,598	252,457
096 NONREIMBURS COST CENTERS							
100 GIFT, FLOWER, COFFEE SHOP							
100 RENTAL HOUSE			2,685	271			
100 01 RENTAL SPACE							
100 02 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	382,456	3,766	8,790,654	805,076	563,467	82,598	252,457

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS	SOCIAL SERVICE
	11	12	14	15	17	17.01	18
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 PURCHASING							
006 02 PERSONNEL							
006 03 HOSPITAL BILLING							
006 04 NURSING HOME BILLING							
006 05 OTHER ADMINISTRATIVE AND							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY	362,931						
012 CAFETERIA	74,186	90,338					
014 NURSING ADMINISTRATION		2,522	217,788				
015 CENTRAL SERVICES & SUPPLY				14,260			
017 MEDICAL RECORDS & LIBRARY		5,241			259,871		
017 01 NURSING HOME MEDICAL RECO						11,986	
018 SOCIAL SERVICE		1,037					68,622
025 INPAT ROUTINE SRVC CNTRS							
034 ADULTS & PEDIATRICS	73,892	24,523	156,325	10,235	32,320		57,296
034 SKILLED NURSING FACILITY	214,853	19,899				11,986	11,326
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM		682	4,332	284	7,173		
041 ANESTHESIOLOGY					1,732		
044 RADIOLOGY-DIAGNOSTIC		3,784			34,239		
049 LABORATORY		5,568			33,468		
050 RESPIRATORY THERAPY					5,029		
051 PHYSICAL THERAPY		3,214			23,456		
052 OCCUPATIONAL THERAPY		1,037			11,705		
053 SPEECH PATHOLOGY					314		
055 ELECTROCARDIOLOGY					1,573		
056 MEDICAL SUPPLIES CHARGED					8,124		
060 DRUGS CHARGED TO PATIENTS		1,859			27,251		
061 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
062 EMERGENCY		8,959	57,131	3,741	12,680		
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC		9,351			49,887		
063 51 RURAL HEALTH CLINIC 2					1,969		
065 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES		2,438			8,951		
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	362,931	90,338	217,788	14,260	259,871	11,986	68,622
096 NONREIMBURS COST CENTERS							
100 GIFT, FLOWER, COFFEE SHOP							
100 RENTAL HOUSE							
100 01 RENTAL SPACE							
100 02 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	362,931	90,338	217,788	14,260	259,871	11,986	68,622

COST CENTER DESCRIPTION	SUBTOTAL	I & R COST POST STEP-DOWN ADJ	TOTAL
	25	26	27
003 GENERAL SERVICE COST CNTR			
003 01 NEW CAP REL COSTS-BLDG &			
004 NEW CAP REL COSTS-MVBLE E			
005 EMPLOYEE BENEFITS			
006 01 PURCHASING			
006 02 PERSONNEL			
006 03 HOSPITAL BILLING			
006 04 NURSING HOME BILLING			
006 05 OTHER ADMINISTRATIVE AND			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATION			
015 CENTRAL SERVICES & SUPPLY			
017 MEDICAL RECORDS & LIBRARY			
017 01 NURSING HOME MEDICAL RECO			
018 SOCIAL SERVICE			
025 INPAT ROUTINE SRVC CNTRS	2,020,827		2,020,827
034 ADULTS & PEDIATRICS	1,421,482		1,421,482
037 SKILLED NURSING FACILITY			
040 ANCILLARY SRVC COST CNTRS	206,385		206,385
041 OPERATING ROOM	32,030		32,030
044 ANESTHESIOLOGY	455,666		455,666
049 RADIOLOGY-DIAGNOSTIC	554,488		554,488
050 LABORATORY	24,450		24,450
051 RESPIRATORY THERAPY	361,359		361,359
052 PHYSICAL THERAPY	176,328		176,328
053 OCCUPATIONAL THERAPY	3,949		3,949
055 SPEECH PATHOLOGY	7,923		7,923
056 ELECTROCARDIOLOGY	233,749		233,749
060 MEDICAL SUPPLIES CHARGED	429,386		429,386
061 DRUGS CHARGED TO PATIENTS			
062 OUTPAT SERVICE COST CNTRS			
063 CLINIC			
061 EMERGENCY	1,010,168		1,010,168
062 OBSERVATION BEDS (NON-DIS			
063 OTHER OUTPATIENT SERVICE			
063 50 RURAL HEALTH CLINIC	1,437,674		1,437,674
063 51 RURAL HEALTH CLINIC 2	133,972		133,972
065 OTHER REIMBURS COST CNTRS			
095 AMBULANCE SERVICES	277,862		277,862
096 SPEC PURPOSE COST CENTERS			
100 SUBTOTALS	8,787,698		8,787,698
100 01 NONREIMBURS COST CENTERS			
100 02 GIFT, FLOWER, COFFEE SHOP			
101 RENTAL HOUSE	2,956		2,956
102 01 RENTAL SPACE			
102 02 OTHER NONREIMBURSABLE COS			
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 TOTAL	8,790,654		8,790,654

ALLOCATION OF NEW CAPITAL RELATED COSTS

14-1329

FROM 7/ 1/2008

WORKSHEET B

TO 6/30/2009

PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	PURCHASING
	0	3	3.01	4	4a	5	6.01
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 PURCHASING		9,122			9,122		9,122
006 02 PERSONNEL		2,901		377	3,278		179
006 03 HOSPITAL BILLING	298	5,009		1,668	6,975		413
006 04 NURSING HOME BILLING	2	507			509		39
006 05 OTHER ADMINISTRATIVE AND		15,117		8,961	24,078		558
008 OPERATION OF PLANT	176	56,393		779	57,348		274
009 LAUNDRY & LINEN SERVICE		7,181			7,181		
010 HOUSEKEEPING		2,998			2,998		162
011 DIETARY	720	8,308		242	9,270		229
012 CAFETERIA		3,197			3,197		
014 NURSING ADMINISTRATION		4,243			4,243		45
015 CENTRAL SERVICES & SUPPLY		2,804			2,804		6
017 MEDICAL RECORDS & LIBRARY		6,599		1,772	8,371		357
017 01 NURSING HOME MEDICAL RECO		539			539		22
018 SOCIAL SERVICE		825			825		17
025 INPAT ROUTINE SRVC CNTRS							
034 ADULTS & PEDIATRICS	6,026	50,468		15,610	72,104		1,033
037 SKILLED NURSING FACILITY		47,552		420	47,972		960
040 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM		9,392		7,919	17,311		402
044 ANESTHESIOLOGY							
049 RADIOLOGY-DIAGNOSTIC		7,510		34,453	41,963		419
050 LABORATORY		7,580		10,832	18,412		932
051 RESPIRATORY THERAPY	7,750				7,750		
052 PHYSICAL THERAPY	816	7,812		292	8,920		112
053 OCCUPATIONAL THERAPY		2,669		4	2,673		
055 SPEECH PATHOLOGY							
056 ELECTROCARDIOLOGY							
060 MEDICAL SUPPLIES CHARGED							
061 DRUGS CHARGED TO PATIENTS	1,898	2,609		3,550	8,057		100
062 OUTPAT SERVICE COST CNTRS							
063 CLINIC							
063 50 EMERGENCY	1,710	6,750		1,927	10,387		1,132
063 51 OBSERVATION BEDS (NON-DIS							
065 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	700	15,500		14,343	30,543		1,033
063 51 RURAL HEALTH CLINIC 2							
065 OTHER REIMBURS COST CNTRS							
095 AMBULANCE SERVICES		15,204		3,391	18,595		698
096 SPEC PURPOSE COST CENTERS							
100 SUBTOTALS	20,096	298,789		106,540	425,425		9,122
100 01 NONREIMBURS COST CENTERS							
100 02 GIFT, FLOWER, COFFEE SHOP							
101 RENTAL HOUSE							
101 01 RENTAL SPACE							
101 02 OTHER NONREIMBURSABLE COS							
102 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	20,096	298,789		106,540	425,425		9,122

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION		PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	OTHER ADMINISTRATIVE AND	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
		6.02	6.03	6.04	6.05	8	9	10
003	GENERAL SERVICE COST CNTR							
003	01 NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	01 PURCHASING							
006	02 PERSONNEL	3,457						
006	03 HOSPITAL BILLING	144	7,532					
006	04 NURSING HOME BILLING	1		549				
006	05 OTHER ADMINISTRATIVE AND	143			24,779			
008	OPERATION OF PLANT	60			1,588	59,270		
009	LAUNDRY & LINEN SERVICE				178	2,029	9,388	
010	HOUSEKEEPING	122			689	847		4,818
011	DIETARY	136			930	2,348		201
012	CAFETERIA				10	903		77
014	NURSING ADMINISTRATION	113			560	1,199		102
015	CENTRAL SERVICES & SUPPLY				9	792		68
017	MEDICAL RECORDS & LIBRARY	121			644	1,865		159
017	01 NURSING HOME MEDICAL RECO	5			27	152		13
018	SOCIAL SERVICE	37			181	233		20
025	INPAT ROUTINE SRVC CNTRS							
034	ADULTS & PEDIATRICS	731	937		4,079	14,264	2,274	1,219
034	SKILLED NURSING FACILITY	488		549	2,591	13,438	6,406	1,148
037	ANCILLARY SRVC COST CNTRS							
040	OPERATING ROOM	33	208		442	2,654	14	227
040	ANESTHESIOLOGY		50		85			
041	RADIOLOGY-DIAGNOSTIC	132	993		1,090	2,122	162	181
044	LABORATORY	189	971		1,369	2,142		183
049	RESPIRATORY THERAPY		146		55			
050	PHYSICAL THERAPY	149	680		852	2,208	159	189
051	OCCUPATIONAL THERAPY	77	339		431	754		64
052	SPEECH PATHOLOGY		9		10			
053	ELECTROCARDIOLOGY	2	46		18			
055	MEDICAL SUPPLIES CHARGED		236		636			
056	DRUGS CHARGED TO PATIENTS	90	790		1,099	737		63
060	OUTPAT SERVICE COST CNTRS							
060	CLINIC							
061	EMERGENCY	228	368		2,533	1,907	274	163
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063	50 RURAL HEALTH CLINIC	333	1,442		3,712	4,380	55	374
063	51 RURAL HEALTH CLINIC 2	54	57		372			
065	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES	69	260		581	4,296	44	367
095	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	3,457	7,532	549	24,771	59,270	9,388	4,818
096	NONREIMBURS COST CENTERS							
100	GIFT, FLOWER, COFFEE SHOP							
100	RENTAL HOUSE				8			
100	01 RENTAL SPACE							
100	02 OTHER NONREIMBURSABLE COS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	3,457	7,532	549	24,779	59,270	9,388	4,818

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS	SOCIAL SERVICE
		11	12	14	15	17	17.01	18
003	GENERAL SERVICE COST CNTR							
003	01 NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	01 PURCHASING							
006	02 PERSONNEL							
006	03 HOSPITAL BILLING							
006	04 NURSING HOME BILLING							
006	05 OTHER ADMINISTRATIVE AND							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVICE							
010	HOUSEKEEPING							
011	DIETARY	13,114						
012	CAFETERIA	2,681	6,868					
014	NURSING ADMINISTRATION		192	6,454				
015	CENTRAL SERVICES & SUPPLY				3,679			
017	MEDICAL RECORDS & LIBRARY		398			11,915		
017	01 NURSING HOME MEDICAL RECO		17				775	
018	SOCIAL SERVICE		79					1,392
025	INPAT ROUTINE SRVC CNTRS							
034	ADULTS & PEDIATRICS	2,670	1,865	4,633	2,641	1,482		1,162
034	SKILLED NURSING FACILITY	7,763	1,513				775	230
037	ANCILLARY SRVC COST CNTRS							
040	OPERATING ROOM		52	128	73	329		
041	ANESTHESIOLOGY					79		
041	RADIOLOGY-DIAGNOSTIC		288			1,570		
044	LABORATORY		423			1,535		
049	RESPIRATORY THERAPY					231		
050	PHYSICAL THERAPY		244			1,076		
051	OCCUPATIONAL THERAPY		79			537		
052	SPEECH PATHOLOGY					14		
053	ELECTROCARDIOLOGY					72		
055	MEDICAL SUPPLIES CHARGED					373		
056	DRUGS CHARGED TO PATIENTS		141			1,250		
060	OUTPAT SERVICE COST CNTRS							
061	CLINIC							
061	EMERGENCY		681	1,693	965	581		
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063	50 RURAL HEALTH CLINIC		711			2,286		
063	51 RURAL HEALTH CLINIC 2					90		
065	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES		185			410		
095	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	13,114	6,868	6,454	3,679	11,915	775	1,392
096	NONREIMBURS COST CENTERS							
100	GIFT, FLOWER, COFFEE SHOP							
100	RENTAL HOUSE							
100	01 RENTAL SPACE							
100	02 OTHER NONREIMBURSABLE COS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	13,114	6,868	6,454	3,679	11,915	775	1,392

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	25	26	27
003 GENERAL SERVICE COST CNTR			
003 01 NEW CAP REL COSTS-BLDG &			
004 NEW CAP REL COSTS-MVBLE E			
005 EMPLOYEE BENEFITS			
006 01 PURCHASING			
006 02 PERSONNEL			
006 03 HOSPITAL BILLING			
006 04 NURSING HOME BILLING			
006 05 OTHER ADMINISTRATIVE AND			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATION			
015 CENTRAL SERVICES & SUPPLY			
017 MEDICAL RECORDS & LIBRARY			
017 01 NURSING HOME MEDICAL RECO			
018 SOCIAL SERVICE			
INPAT ROUTINE SRVC CNTRS			
025 ADULTS & PEDIATRICS	111,094		111,094
034 SKILLED NURSING FACILITY	83,833		83,833
ANCILLARY SRVC COST CNTRS			
037 OPERATING ROOM	21,873		21,873
040 ANESTHESIOLOGY	214		214
041 RADIOLOGY-DIAGNOSTIC	48,920		48,920
044 LABORATORY	26,156		26,156
049 RESPIRATORY THERAPY	8,182		8,182
050 PHYSICAL THERAPY	14,589		14,589
051 OCCUPATIONAL THERAPY	4,954		4,954
052 SPEECH PATHOLOGY	33		33
053 ELECTROCARDIOLOGY	138		138
055 MEDICAL SUPPLIES CHARGED	1,245		1,245
056 DRUGS CHARGED TO PATIENTS	12,327		12,327
OUTPAT SERVICE COST CNTRS			
060 CLINIC			
061 EMERGENCY	20,912		20,912
062 OBSERVATION BEDS (NON-DIS			
063 OTHER OUTPATIENT SERVICE			
063 50 RURAL HEALTH CLINIC	44,869		44,869
063 51 RURAL HEALTH CLINIC 2	573		573
OTHER REIMBURS COST CNTRS			
065 AMBULANCE SERVICES	25,505		25,505
SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	425,417		425,417
NONREIMBURS COST CENTERS			
096 GIFT, FLOWER, COFFEE SHOP			
100 RENTAL HOUSE	8		8
100 01 RENTAL SPACE			
100 02 OTHER NONREIMBURSABLE COS			
101 CROSS FOOT ADJUSTMENTS			
102 NEGATIVE COST CENTER			
103 TOTAL	425,425		425,425

COST CENTER DESCRIPTION	NEW CAP REL C OSTS-BLDG & (SQUARE FEET)	NEW CAP REL C OSTS-BLDG & (SQUARE FEET)	NEW CAP REL C OSTS-MVBLE E (DOLLAR VALUE)	EMPLOYEE BENE PURCHASING PERSONNEL (GROSS SALARIES) (PURCHASE ORDE (GROSS SALARIES)
	3	3.01	4	5 6.01 6.02
003 GENERAL SERVICE COST				
003 01 NEW CAP REL COSTS-BLD	55,420			
004 NEW CAP REL COSTS-MVB		55,420		
005 EMPLOYEE BENEFITS			285,392	4,600,278
006 01 PURCHASING	1,692	1,692		23,143
006 02 PERSONNEL	538	538	1,010	92,052
006 03 HOSPITAL BILLING	929	929	4,469	186,895
006 04 NURSING HOME BILLING	94	94		1,534
006 05 OTHER ADMINISTRATIVE	2,804	2,804	24,004	185,850
008 OPERATION OF PLANT	10,460	10,460	2,086	77,411
009 LAUNDRY & LINEN SERVI	1,332	1,332		
010 HOUSEKEEPING	556	556		157,619
011 DIETARY	1,541	1,541	648	176,129
012 CAFETERIA	593	593		
014 NURSING ADMINISTRATION	787	787		146,901
015 CENTRAL SERVICES & SU	520	520		
017 MEDICAL RECORDS & LIB	1,224	1,224	4,747	157,491
017 01 NURSING HOME MEDICAL	100	100		6,339
018 SOCIAL SERVICE	153	153		48,502
025 INPAT ROUTINE SRVC CN				
034 ADULTS & PEDIATRICS	9,361	9,361	41,816	948,604
034 SKILLED NURSING FACIL	8,820	8,820	1,126	633,127
037 ANCILLARY SRVC COST C				
040 OPERATING ROOM	1,742	1,742	21,212	42,787
041 ANESTHESIOLOGY				
041 RADIOLOGY-DIAGNOSTIC	1,393	1,393	92,288	171,029
044 LABORATORY	1,406	1,406	29,016	245,222
049 RESPIRATORY THERAPY				
050 PHYSICAL THERAPY	1,449	1,449	782	193,332
051 OCCUPATIONAL THERAPY	495	495	12	99,858
052 SPEECH PATHOLOGY				
053 ELECTROCARDIOLOGY				2,942
055 MEDICAL SUPPLIES CHAR				
056 DRUGS CHARGED TO PATI	484	484	9,509	116,400
060 OUTPAT SERVICE COST C				
061 CLINIC				
061 EMERGENCY	1,252	1,252	5,162	295,558
062 OBSERVATION BEDS (NON				
063 OTHER OUTPATIENT SERV				
063 50 RURAL HEALTH CLINIC	2,875	2,875	38,421	431,913
063 51 RURAL HEALTH CLINIC 2				69,527
065 OTHER REIMBURS COST C				
065 AMBULANCE SERVICES	2,820	2,820	9,084	90,113
095 SPEC PURPOSE COST CEN				
095 SUBTOTALS	55,420	55,420	285,392	4,600,278
096 NONREIMBURS COST CENT				
100 GIFT, FLOWER, COFFEE				
100 RENTAL HOUSE				
100 01 RENTAL SPACE				
100 02 OTHER NONREIMBURSABLE				
101 CROSS FOOT ADJUSTMENT				
102 NEGATIVE COST CENTER				
103 COST TO BE ALLOCATED	298,789		106,540	639,016
(WRKSHT B, PART I)				40,881
104 UNIT COST MULTIPLIER	5.391357		.373311	25.018972
(WRKSHT B, PT I)				.138908
105 COST TO BE ALLOCATED				
(WRKSHT B, PART II)				
106 UNIT COST MULTIPLIER				
(WRKSHT B, PT II)				
107 COST TO BE ALLOCATED				9,122
(WRKSHT B, PART III)				3,457
108 UNIT COST MULTIPLIER				5.582619
(WRKSHT B, PT III)				.000771

COST CENTER DESCRIPTION	HOSPITAL BILLING	NURSING HOME BILLING	RECONCILIATION	OTHER ADMINISTRATIVE AND	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		HOUSEKEEPING
						(NON-NURSING HOME CHARGES)	(NURSING HOME CHARGES)	
	6.03	6.04	6a.05	6.05	8	9	10	
GENERAL SERVICE COST								
003 NEW CAP REL COSTS-BLD								
003 01 NEW CAP REL COSTS-BLD								
004 NEW CAP REL COSTS-MVB								
005 EMPLOYEE BENEFITS								
006 01 PURCHASING								
006 02 PERSONNEL								
006 03 HOSPITAL BILLING	9,799,845							
006 04 NURSING HOME BILLING		1,367,042						
006 05 OTHER ADMINISTRATIVE			-805,076	7,985,578				
008 OPERATION OF PLANT				511,863	38,903			
009 LAUNDRY & LINEN SERVICE				57,507	1,332	26,829		
010 HOUSEKEEPING				222,021	556			37,015
011 DIETARY				299,869	1,541			1,541
012 CAFETERIA				3,197	593			593
014 NURSING ADMINISTRATION				180,320	787			787
015 CENTRAL SERVICES & SUPPLIES				2,890	520			520
017 MEDICAL RECORDS & LIBRARY				207,622	1,224			1,224
017 01 NURSING HOME MEDICAL				8,750	100			100
018 SOCIAL SERVICE				58,434	153			153
025 INPATIENT ROUTINE SERVICES	1,218,810							
034 SKILLED NURSING FACILITY		1,367,042		1,314,294	9,361	6,500		9,361
ANCILLARY SERVICE COST CENTER				834,976	8,820	18,306		8,820
037 OPERATING ROOM	270,495			142,330	1,742	40		1,742
040 ANESTHESIOLOGY	65,320			27,523				
041 RADIOLOGY-DIAGNOSTIC	1,291,175			351,140	1,393	463		1,393
044 LABORATORY	1,262,103			441,036	1,406			1,406
049 RESPIRATORY THERAPY	189,660			17,642				
050 PHYSICAL THERAPY	884,525			274,724	1,449	454		1,449
051 OCCUPATIONAL THERAPY	441,407			139,024	495			495
052 SPEECH PATHOLOGY	11,846			3,302				
053 ELECTROCARDIOLOGY	59,315			5,768				
055 MEDICAL SUPPLIES CHARGED TO PATIENT	306,340			204,962				
056 DRUGS CHARGED TO PATIENT	1,027,657			354,251	484			484
060 OUTPATIENT SERVICE COST CENTER								
061 EMERGENCY	478,179			816,282	1,252	782		1,252
062 OBSERVATION BEDS (NON-REIMBURSABLE)								
063 OTHER OUTPATIENT SERVICE								
063 50 RURAL HEALTH CLINIC	1,881,205			1,196,113	2,875	158		2,875
063 51 RURAL HEALTH CLINIC 2	74,268			119,914				
065 OTHER REIMBURSABLE COST CENTER								
AMBULANCE SERVICES	337,540			187,139	2,820	126		2,820
SPECIAL PURPOSE COST CENTER								
095 SUBTOTALS	9,799,845	1,367,042	-805,076	7,982,893	38,903	26,829		37,015
NONREIMBURSABLE COST CENTER								
096 GIFT, FLOWER, COFFEE								
100 RENTAL HOUSE				2,685				
100 01 RENTAL SPACE								
100 02 OTHER NONREIMBURSABLE								
CROSS FOOT ADJUSTMENT								
102 NEGATIVE COST CENTER								
103 COST TO BE ALLOCATED (WRKSHT B, PART I)	382,456	3,766		805,076	563,467	82,598		252,457
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)	.039027	.002755		.100816	14.483896	3.078684		6.820397
105 COST TO BE ALLOCATED (WRKSHT B, PART II)								
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)								
107 COST TO BE ALLOCATED (WRKSHT B, PART III)	7,532	549		24,779	59,270	9,388		4,818
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)	.000769	.000402		.003103	1.523533	.349920		.130163

COST CENTER DESCRIPTION	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (COSTED) EQUI S.	CENTRAL SERVICES & SUPPLY (COSTED) EQUI S.	MEDICAL RECORDS & LIBRARY (NON-NURSING HOME CHARGES)	NURSING HOME MEDICAL RECORDS (NURSING HOME CHARGES)	SOCIAL SERVICE (TIME SPENT)
	11	12	14	15	17	17.01	18
GENERAL SERVICE COST							
003 NEW CAP REL COSTS-BLD							
003 01 NEW CAP REL COSTS-BLD							
004 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 01 PURCHASING							
006 02 PERSONNEL							
006 03 HOSPITAL BILLING							
006 04 NURSING HOME BILLING							
006 05 OTHER ADMINISTRATIVE OPERATION OF PLANT							
008 LAUNDRY & LINEN SERVICE							
009 HOUSEKEEPING							
010 DIETARY	45,585						
012 CAFETERIA	9,318	9,670					
014 NURSING ADMINISTRATION		270	69,735				
015 CENTRAL SERVICES & SUPPLY				69,735			
017 MEDICAL RECORDS & LIBRARY		561			9,799,845		
017 01 NURSING HOME MEDICAL		24				1,367,042	
018 SOCIAL SERVICE		111					309
025 INPAT ROUTINE SRVC CN ADULTS & PEDIATRICS	9,281	2,625	50,055	50,055	1,218,810		258
034 SKILLED NURSING FACILITY	26,986	2,130				1,367,042	51
037 ANCILLARY SRVC COST CENTER OPERATING ROOM		73	1,387	1,387	270,495		
040 ANESTHESIOLOGY					65,320		
041 RADIOLOGY-DIAGNOSTIC		405			1,291,175		
044 LABORATORY		596			1,262,103		
049 RESPIRATORY THERAPY					189,660		
050 PHYSICAL THERAPY		344			884,525		
051 OCCUPATIONAL THERAPY		111			441,407		
052 SPEECH PATHOLOGY					11,846		
053 ELECTROCARDIOLOGY					59,315		
055 MEDICAL SUPPLIES CHARGED TO PATIENT					306,340		
056 DRUGS CHARGED TO PATIENT OUTPAT SERVICE COST CENTER CLINIC		199			1,027,657		
060 EMERGENCY		959	18,293	18,293	478,179		
062 OBSERVATION BEDS (NON)							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC		1,001			1,881,205		
063 51 RURAL HEALTH CLINIC 2					74,268		
065 OTHER REIMBURSABLE COST CENTER AMBULANCE SERVICES SPEC PURPOSE COST CENTER		261			337,540		
095 SUBTOTALS	45,585	9,670	69,735	69,735	9,799,845	1,367,042	309
096 NONREIMBURSABLE COST CENTER GIFT, FLOWER, COFFEE							
100 RENTAL HOUSE							
100 01 RENTAL SPACE							
100 02 OTHER NONREIMBURSABLE CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED (WRKSHT B, PART I)	362,931	90,338	217,788	14,260	259,871	11,986	68,622
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)	7.961632	9.342089	3.123080	.204488	.026518	.008768	222.077670
105 COST TO BE ALLOCATED (WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107 COST TO BE ALLOCATED (WRKSHT B, PART III)	13,114	6,868	6,454	3,679	11,915	775	1,392
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)	.287682	.710238	.092550	.052757	.001216	.000567	4.504854

COMPUTATION OF RATIO OF COSTS TO CHARGES

PROVIDER NO:	PERIOD:	PREPARED 11/24/2009
14-1329	FROM 7/ 1/2008	WORKSHEET C
	TO 6/30/2009	PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DI ALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,020,827		2,020,827		2,020,827
34	SKILLED NURSING FACILITY	1,421,482		1,421,482		1,421,482
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	206,385		206,385		206,385
40	ANESTHESIOLOGY	32,030		32,030		32,030
41	RADIOLOGY-DIAGNOSTIC	455,666		455,666		455,666
44	LABORATORY	554,488		554,488		554,488
49	RESPIRATORY THERAPY	24,450		24,450		24,450
50	PHYSICAL THERAPY	361,359		361,359		361,359
51	OCCUPATIONAL THERAPY	176,328		176,328		176,328
52	SPEECH PATHOLOGY	3,949		3,949		3,949
53	ELECTROCARDIOLOGY	7,923		7,923		7,923
55	MEDICAL SUPPLIES CHARGED	233,749		233,749		233,749
56	DRUGS CHARGED TO PATIENTS	429,386		429,386		429,386
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	1,010,168		1,010,168		1,010,168
62	OBSERVATION BEDS (NON-DIS	44,045		44,045		44,045
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	1,437,674		1,437,674		1,437,674
63	51 RURAL HEALTH CLINIC 2	133,972		133,972		133,972
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	277,862		277,862		277,862
101	SUBTOTAL	8,831,743		8,831,743		8,831,743
102	LESS OBSERVATION BEDS	44,045		44,045		44,045
103	TOTAL	8,787,698		8,787,698		8,787,698

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,124,201		1,124,201			
34	SKILLED NURSING FACILITY	1,367,042		1,367,042			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	309	270,186	270,495	.762990	.762990	.762990
40	ANESTHESIOLOGY		65,320	65,320	.490355	.490355	.490355
41	RADIOLOGY-DIAGNOSTIC	54,689	1,236,486	1,291,175	.352908	.352908	.352908
44	LABORATORY	157,374	1,104,729	1,262,103	.439337	.439337	.439337
49	RESPIRATORY THERAPY	104,026	85,634	189,660	.128915	.128915	.128915
50	PHYSICAL THERAPY	460,113	424,412	884,525	.408535	.408535	.408535
51	OCCUPATIONAL THERAPY	355,228	86,179	441,407	.399468	.399468	.399468
52	SPEECH PATHOLOGY	8,676	3,170	11,846	.333361	.333361	.333361
53	ELECTROCARDIOLOGY	12,384	46,931	59,315	.133575	.133575	.133575
55	MEDICAL SUPPLIES CHARGED	148,304	158,036	306,340	.763038	.763038	.763038
56	DRUGS CHARGED TO PATIENTS	622,237	405,420	1,027,657	.417830	.417830	.417830
	OUTPAT SERVICE COST CNTRS						
	CLINIC						
60	EMERGENCY	3,324	474,855	478,179	2.112531	2.112531	2.112531
62	OBSERVATION BEDS (NON-DIS		94,609	94,609	.465548	.465548	.465548
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		1,881,205	1,881,205	.764230	.764230	.764230
63	51 RURAL HEALTH CLINIC 2		74,268	74,268	1.803899	1.803899	1.803899
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		337,540	337,540	.823197	.823197	.823197
101	SUBTOTAL	4,417,907	6,748,980	11,166,887			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,417,907	6,748,980	11,166,887			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 14-1329
PERIOD: FROM 7/1/2008 TO 6/30/2009
PREPARED 11/24/2009
WORKSHEET C
PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DI ALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,020,827		2,020,827		2,020,827
34	SKILLED NURSING FACILITY	1,421,482		1,421,482		1,421,482
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	206,385		206,385		206,385
40	ANESTHESIOLOGY	32,030		32,030		32,030
41	RADIOLOGY-DIAGNOSTIC	455,666		455,666		455,666
44	LABORATORY	554,488		554,488		554,488
49	RESPIRATORY THERAPY	24,450		24,450		24,450
50	PHYSICAL THERAPY	361,359		361,359		361,359
51	OCCUPATIONAL THERAPY	176,328		176,328		176,328
52	SPEECH PATHOLOGY	3,949		3,949		3,949
53	ELECTROCARDIOLOGY	7,923		7,923		7,923
55	MEDICAL SUPPLIES CHARGED	233,749		233,749		233,749
56	DRUGS CHARGED TO PATIENTS	429,386		429,386		429,386
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	1,010,168		1,010,168		1,010,168
62	OBSERVATION BEDS (NON-DIS	44,045		44,045		44,045
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	1,437,674		1,437,674		1,437,674
63 51	RURAL HEALTH CLINIC 2	133,972		133,972		133,972
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	277,862		277,862		277,862
101	SUBTOTAL	8,831,743		8,831,743		8,831,743
102	LESS OBSERVATION BEDS	44,045		44,045		44,045
103	TOTAL	8,787,698		8,787,698		8,787,698

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,124,201		1,124,201			
34	SKILLED NURSING FACILITY	1,367,042		1,367,042			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	309	270,186	270,495	.762990	.762990	.762990
40	ANESTHESIOLOGY		65,320	65,320	.490355	.490355	.490355
41	RADIOLOGY-DIAGNOSTIC	54,689	1,236,486	1,291,175	.352908	.352908	.352908
44	LABORATORY	157,374	1,104,729	1,262,103	.439337	.439337	.439337
49	RESPIRATORY THERAPY	104,026	85,634	189,660	.128915	.128915	.128915
50	PHYSICAL THERAPY	460,113	424,412	884,525	.408535	.408535	.408535
51	OCCUPATIONAL THERAPY	355,228	86,179	441,407	.399468	.399468	.399468
52	SPEECH PATHOLOGY	8,676	3,170	11,846	.333361	.333361	.333361
53	ELECTROCARDIOLOGY	12,384	46,931	59,315	.133575	.133575	.133575
55	MEDICAL SUPPLIES CHARGED	148,304	158,036	306,340	.763038	.763038	.763038
56	DRUGS CHARGED TO PATIENTS	622,237	405,420	1,027,657	.417830	.417830	.417830
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	3,324	474,855	478,179	2.112531	2.112531	2.112531
62	OBSERVATION BEDS (NON-DIS		94,609	94,609	.465548	.465548	.465548
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		1,881,205	1,881,205	.764230	.764230	.764230
63	51 RURAL HEALTH CLINIC 2		74,268	74,268	1.803899	1.803899	1.803899
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		337,540	337,540	.823197	.823197	.823197
101	SUBTOTAL	4,417,907	6,748,980	11,166,887			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,417,907	6,748,980	11,166,887			

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	206,385	21,873	184,512			206,385
40	ANESTHESIOLOGY	32,030	214	31,816			32,030
41	RADIOLOGY-DIAGNOSTIC	455,666	48,920	406,746			455,666
44	LABORATORY	554,488	26,156	528,332			554,488
49	RESPIRATORY THERAPY	24,450	8,182	16,268			24,450
50	PHYSICAL THERAPY	361,359	14,589	346,770			361,359
51	OCCUPATIONAL THERAPY	176,328	4,954	171,374			176,328
52	SPEECH PATHOLOGY	3,949	33	3,916			3,949
53	ELECTROCARDIOLOGY	7,923	138	7,785			7,923
55	MEDICAL SUPPLIES CHARGED	233,749	1,245	232,504			233,749
56	DRUGS CHARGED TO PATIENTS	429,386	12,327	417,059			429,386
	OUTPAT SERVICE COST CNTRS						
	CLINIC						
60	EMERGENCY	1,010,168	20,912	989,256			1,010,168
62	OBSERVATION BEDS (NON-DIS	44,045		44,045			44,045
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	1,437,674	44,869	1,392,805			1,437,674
63	51 RURAL HEALTH CLINIC 2	133,972	573	133,399			133,972
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	277,862	25,505	252,357			277,862
101	SUBTOTAL	5,389,434	230,490	5,158,944			5,389,434
102	LESS OBSERVATION BEDS	44,045		44,045			44,045
103	TOTAL	5,345,389	230,490	5,114,899			5,345,389

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	270,495	.762990	.762990
40	ANESTHESIOLOGY	65,320	.490355	.490355
41	RADIOLOGY-DIAGNOSTIC	1,291,175	.352908	.352908
44	LABORATORY	1,262,103	.439337	.439337
49	RESPIRATORY THERAPY	189,660	.128915	.128915
50	PHYSICAL THERAPY	884,525	.408535	.408535
51	OCCUPATIONAL THERAPY	441,407	.399468	.399468
52	SPEECH PATHOLOGY	11,846	.333361	.333361
53	ELECTROCARDIOLOGY	59,315	.133575	.133575
55	MEDICAL SUPPLIES CHARGED	306,340	.763038	.763038
56	DRUGS CHARGED TO PATIENTS	1,027,657	.417830	.417830
	OUTPAT SERVICE COST CNTRS			
	CLINIC			
60	EMERGENCY	478,179	2.112531	2.112531
62	OBSERVATION BEDS (NON-DIS	94,609	.465548	.465548
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	1,881,205	.764230	.764230
63	51 RURAL HEALTH CLINIC 2	74,268	1.803899	1.803899
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	337,540	.823197	.823197
101	SUBTOTAL	8,675,644		
102	LESS OBSERVATION BEDS	94,609		
103	TOTAL	8,581,035		

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	206,385	21,873	184,512			206,385
40	ANESTHESIOLOGY	32,030	214	31,816			32,030
41	RADIOLOGY-DIAGNOSTIC	455,666	48,920	406,746			455,666
44	LABORATORY	554,488	26,156	528,332			554,488
49	RESPIRATORY THERAPY	24,450	8,182	16,268			24,450
50	PHYSICAL THERAPY	361,359	14,589	346,770			361,359
51	OCCUPATIONAL THERAPY	176,328	4,954	171,374			176,328
52	SPEECH PATHOLOGY	3,949	33	3,916			3,949
53	ELECTROCARDIOLOGY	7,923	138	7,785			7,923
55	MEDICAL SUPPLIES CHARGED	233,749	1,245	232,504			233,749
56	DRUGS CHARGED TO PATIENTS	429,386	12,327	417,059			429,386
	OUTPAT SERVICE COST CNTRS						
	CLINIC						
60	EMERGENCY	1,010,168	20,912	989,256			1,010,168
62	OBSERVATION BEDS (NON-DIS	44,045		44,045			44,045
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	1,437,674	44,869	1,392,805			1,437,674
63	51 RURAL HEALTH CLINIC 2	133,972	573	133,399			133,972
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	277,862	25,505	252,357			277,862
101	SUBTOTAL	5,389,434	230,490	5,158,944			5,389,434
102	LESS OBSERVATION BEDS	44,045		44,045			44,045
103	TOTAL	5,345,389	230,490	5,114,899			5,345,389

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	270,495	.762990	.762990
40	ANESTHESIOLOGY	65,320	.490355	.490355
41	RADIOLOGY-DIAGNOSTIC	1,291,175	.352908	.352908
44	LABORATORY	1,262,103	.439337	.439337
49	RESPIRATORY THERAPY	189,660	.128915	.128915
50	PHYSICAL THERAPY	884,525	.408535	.408535
51	OCCUPATIONAL THERAPY	441,407	.399468	.399468
52	SPEECH PATHOLOGY	11,846	.333361	.333361
53	ELECTROCARDIOLOGY	59,315	.133575	.133575
55	MEDICAL SUPPLIES CHARGED	306,340	.763038	.763038
56	DRUGS CHARGED TO PATIENTS	1,027,657	.417830	.417830
	OUTPAT SERVICE COST CNTRS			
	CLINIC			
60	EMERGENCY	478,179	2.112531	2.112531
62	OBSERVATION BEDS (NON-DIS	94,609	.465548	.465548
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	1,881,205	.764230	.764230
63	51 RURAL HEALTH CLINIC 2	74,268	1.803899	1.803899
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	337,540	.823197	.823197
101	SUBTOTAL	8,675,644		
102	LESS OBSERVATION BEDS	94,609		
103	TOTAL	8,581,035		

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	137,449	326,716			
40	ANESTHESIOLOGY	903	24,046			
41	RADIOLOGY-DIAGNOSTIC	481,166	1,043,003			
44	LABORATORY	496,789	1,062,896			
49	RESPIRATORY THERAPY	7,377	169,842			
50	PHYSICAL THERAPY	340,722	732,715			
51	OCCUPATIONAL THERAPY	147,997	392,942			
52	SPEECH PATHOLOGY	1,453	1,213			
53	ELECTROCARDIOLOGY	3,401	25,746			
55	MEDICAL SUPPLIES CHARGED	205,029	301,836			
56	DRUGS CHARGED TO PATIENTS	315,241	755,764			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	895,884	589,650			
62	OBSERVATION BEDS (NON-DIS	10,069	25,434			
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	1,323,588	1,643,214			
63 51	RURAL HEALTH CLINIC 2	267,170	167,178			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	217,753	333,950			
101	TOTAL	4,851,991	7,596,145			

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	137,449		137,449	326,716			
40	ANESTHESIOLOGY	903		903	24,046			
41	RADIOLOGY-DIAGNOSTIC	481,166		481,166	1,043,003			
44	LABORATORY	496,789		496,789	1,062,896			
49	RESPIRATORY THERAPY	7,377		7,377	169,842			
50	PHYSICAL THERAPY	340,722		340,722	732,715			
51	OCCUPATIONAL THERAPY	147,997		147,997	392,942			
52	SPEECH PATHOLOGY	1,453		1,453	1,213			
53	ELECTROCARDIOLOGY	3,401	3,313	6,714	25,746			
55	MEDICAL SUPPLIES CHARGED	205,029		205,029	301,836			
56	DRUGS CHARGED TO PATIENTS	315,241		315,241	755,764			
	OUTPAT SERVICE COST CNTRS							
60	CLINIC							
61	EMERGENCY	895,884	71,522	967,406	589,650			
62	OBSERVATION BEDS (NON-DIS	10,069		10,069	25,434			
63	OTHER OUTPATIENT SERVICE							
63	50 RURAL HEALTH CLINIC							
63	51 RURAL HEALTH CLINIC 2							
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES	217,753		217,753	333,950			
101	TOTAL	3,261,233	74,835	3,336,068	5,785,753			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

TITLE XVIII PART A HOSPITAL OTHER

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1
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	53
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	831.04
85	OBSERVATION BED COST	44,045

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 XVIII PART A SNF PPS

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1,421,482
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	154.73
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	83,833
72	PER DIEM CAPITAL-RELATED COSTS	9.13
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

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		171,639	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.762990	309	236
40	ANESTHESIOLOGY	.490355		
41	RADIOLOGY-DIAGNOSTIC	.352908	13,545	4,780
44	LABORATORY	.439337	47,029	20,662
49	RESPIRATORY THERAPY	.128915	50,832	6,553
50	PHYSICAL THERAPY	.408535	3,651	1,492
51	OCCUPATIONAL THERAPY	.399468	2,250	899
52	SPEECH PATHOLOGY	.333361		
53	ELECTROCARDIOLOGY	.133575	11,151	1,489
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.763038	12,406	9,466
56	DRUGS CHARGED TO PATIENTS	.417830	92,472	38,638
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	2.112531		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.465548		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
63 51	RURAL HEALTH CLINIC 2			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		233,645	84,215
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		233,645	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	982,992
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)	982,992

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES		
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	992,822
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	CAH DEDUCTIBLES	6,121
18.01	CAH ACTUAL BILLED COINSURANCE	247,447
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	739,254
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	739,254
24	PRIMARY PAYER PAYMENTS	
25	SUBTOTAL	739,254

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	43,212
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	43,212
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	43,112
28	SUBTOTAL	782,466
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	782,466
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	737,472
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	44,994
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2	

TO BE COMPLETED BY CONTRACTOR

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

TITLE XVII HOSPITAL

DESCRIPTION	INPATIENT-PART A		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		245,220		707,657
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			5/15/2009	48,888
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	1/30/2009	14,526	1/30/2009	19,073
ADJUSTMENTS TO PROGRAM .51	5/15/2009	3,233		
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		-17,759		29,815
4 TOTAL INTERIM PAYMENTS		227,461		737,472
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)				44,994
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02		2,948		
7 TOTAL MEDICARE PROGRAM LIABILITY		224,513		782,466

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.

TITLE XVII I SWING BED SNF

DESCRIPTION	INPATIENT-PART A		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,799,212		
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	1/30/2009	31,786		
ADJUSTMENTS TO PROVIDER .02	5/15/2009	156,801		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		188,587		NONE
4 TOTAL INTERIM PAYMENTS		1,987,799		
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)		5,435		
7 TOTAL MEDICARE PROGRAM LIABILITY		1,993,234		

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.

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES		267,873
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		
2	ORGAN ACQUISITION		
3	COST OF TEACHING PHYSICIANS		
4	SUBTOTAL		267,873
5	PRIMARY PAYER PAYMENTS		
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)		270,552
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
7	ROUTINE SERVICE CHARGES		
8	ANCI LLARY SERVICE CHARGES		
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		
10	TEACHING PHYSICIANS		
11	TOTAL REASONABLE CHARGES		
CUSTOMARY CHARGES			
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)		
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18	DI RECT GRADUATE MEDICAL EDUCATION PAYMENTS		
19	COST OF COVERED SERVICES		270,552
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		49,566
21	EXCESS REASONABLE COST		
22	SUBTOTAL		220,986
23	COI NSURANCE		1,815
24	SUBTOTAL		219,171
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)		5,342
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		5,342
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		5,342
26	SUBTOTAL		224,513
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTI LIZATION		
28	OTHER ADJUSTMENTS (SPECIFY)		
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DI SPOSITION OF DEPRECIABLE ASSETS		
30	SUBTOTAL		224,513
31	SEQUESTRATION ADJUSTMENT		
32	INTERIM PAYMENTS		227,461
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
33	BALANCE DUE PROVIDER/PROGRAM		-2,948
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2.		

	GENERAL FUND	SPECIFIC FUND PURPOSE	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	1,292,495			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	1,438,644			
5 OTHER RECEIVABLES	740,195			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7 INVENTORY	131,254			
8 PREPAID EXPENSES	85,693			
9 OTHER CURRENT ASSETS	16,967			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	3,705,248			
FIXED ASSETS				
12 LAND	271,657			
12.01 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	2,399,399			
14.01 LESS ACCUMULATED DEPRECIATION				
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT				
18.01 LESS ACCUMULATED DEPRECIATION				
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	2,671,056			
OTHER ASSETS				
22 INVESTMENTS	726,900			
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS				
26 TOTAL OTHER ASSETS	726,900			
27 TOTAL ASSETS	7,103,204			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	312,745			
29 SALARIES, WAGES & FEES PAYABLE	265,110			
30 PAYROLL TAXES PAYABLE	101,722			
31 NOTES AND LOANS PAYABLE (SHORT TERM)	1,283,271			
32 DEFERRED INCOME	391,500			
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	39,577			
36 TOTAL CURRENT LIABILITIES	2,393,925			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	118,190			
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	118,190			
43 TOTAL LIABILITIES	2,512,115			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	4,591,089			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	4,591,089			
52 TOTAL LIABILITIES AND FUND BALANCES	7,103,204			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND	SPECIFIC PURPOSE FUND
	1	2
1 FUND BALANCE AT BEGINNING		4,206,388
2 OF PERIOD		
3 NET INCOME (LOSS)		384,695
4 TOTAL		4,591,083
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6 ADDITIONS (CREDIT ADJUSTM		
7 ROUNDING	6	
8		
9		
10 TOTAL ADDITIONS		6
11 SUBTOTAL		4,591,089
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13 DEDUCTIONS (DEBIT ADJUSTM		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		4,591,089
PERIOD PER BALANCE SHEET		

	ENDOWMENT FUND	PLANT FUND
	5	6
1 FUND BALANCE AT BEGINNING		
2 OF PERIOD		
3 NET INCOME (LOSS)		
4 TOTAL		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6 ADDITIONS (CREDIT ADJUSTM		
7 ROUNDING		
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	307,028		307,028
4 00 SWING BED - SNF	782,676		782,676
5 00 SWING BED - NF	135,487		135,487
6 00 SKILLED NURSING FACILITY	1,367,042		1,367,042
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,592,233		2,592,233
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	2,592,233		2,592,233
17 00 ANCILLARY SERVICES	1,820,726	4,688,762	6,509,488
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC		1,895,562	1,895,562
18 51 RURAL HEALTH CLINIC 2		74,268	74,268
20 00 AMBULANCE SERVICES		337,540	337,540
24 00 PROFESSIONAL FEES		9,761	9,761
24 01 ROUNDING		-3	-3
25 00 TOTAL PATIENT REVENUES	4,412,959	7,005,890	11,418,849

PART II - OPERATING EXPENSES

26 00 OPERATING EXPENSES		9,054,129	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		9,054,129	

DESCRIPTION

1	TOTAL PATIENT REVENUES	11,418,849
2	LESS: ALLOWANCES AND DISCOUNTS ON	2,342,642
3	NET PATIENT REVENUES	9,076,207
4	LESS: TOTAL OPERATING EXPENSES	9,054,129
5	NET INCOME FROM SERVICE TO PATIENT	22,078
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	1,535
7	INCOME FROM INVESTMENTS	39,061
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER OP REV	187,955
24.01	COUNTY TAX	742,130
24.02	STATE TAX	88,892
25	TOTAL OTHER INCOME	1,059,573
26	TOTAL	1,081,651
	OTHER EXPENSES	
27	BAD DEBTS	667,171
28	CHARITY CARE	29,785
29		
30	TOTAL OTHER EXPENSES	696,956
31	NET INCOME (OR LOSS) FOR THE PERIO	384,695

RHC 2

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1 PHYSICIAN		2,390	2,390	
2 PHYSICIAN ASSISTANT				
3 NURSE PRACTITIONER				
4 VISITING NURSE				
5 OTHER NURSE				
6 CLINICAL PSYCHOLOGIST				
7 CLINICAL SOCIAL WORKER				
8 LABORATORY TECHNICIAN				
9 OTHER FACILITY HEALTH CARE STAFF COSTS	69,527	12,904	82,431	
10 SUBTOTAL (SUM OF LINES 1-9)	69,527	15,294	84,821	
COSTS UNDER AGREEMENT				
11 PHYSICIAN SERVICES UNDER AGREEMENT				
12 PHYSICIAN SUPERVISION UNDER AGREEMENT				
13 OTHER COSTS UNDER AGREEMENT				
14 SUBTOTAL (SUM OF LINES 11-13)				
OTHER HEALTH CARE COSTS				
15 MEDICAL SUPPLIES		543	543	
16 TRANSPORTATION (HEALTH CARE STAFF)				
17 DEPRECIATION-MEDICAL EQUIPMENT				
18 PROFESSIONAL LIABILITY INSURANCE				
19 OTHER HEALTH CARE COSTS				
20 ALLOWABLE GME COSTS				
21 SUBTOTAL (SUM OF LINES 15-20)		543	543	
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	69,527	15,837	85,364	
COSTS OTHER THAN RHC/FQHC SERVICES				
23 PHARMACY				
24 DENTAL				
25 OPTOMETRY				
26 ALL OTHER NONREIMBURSABLE COSTS				
27 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
FACILITY OVERHEAD				
29 FACILITY COSTS		10,414	10,414	
30 ADMINISTRATIVE COSTS		9,166	9,166	
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		19,580	19,580	
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	69,527	35,417	104,944	

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2008	11/24/2009
COMPONENT NO:	TO 6/30/2009	WORKSHEET M-2
14-3981		

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS		4,200	
2	PHYSICIAN ASSISTANTS	1.00	2,100	2,100
3	NURSE PRACTITIONERS		2,100	
4	SUBTOTAL (SUM OF LINES 1-3)	1.00		2,100
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.00	3,559	
9	PHYSICIAN SERVICES UNDER AGREEMENTS		14,671	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	976,388		
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)	976,388		
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)	36,843		
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	424,443		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	461,286		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	461,286		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	461,286		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,437,674		

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED 11/24/2009
14-1329	FROM 7/ 1/2008	WORKSHEET M-2
COMPONENT NO:	TO 6/30/2009	
14-3981		

RHC 1

VISITS AND PRODUCTIVITY

GREATER OF
COL. 2 OR
COL. 4
5

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

3,559

3,559

14,671

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

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED
14-1329	FROM 7/ 1/2008	11/24/2009
COMPONENT NO:	TO 6/30/2009	WORKSHEET M-2
14-3481		

RHC 2

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1			4,200	
2			2,100	
3	1.00	697	2,100	2,100
4	1.00	697		2,100
SUBTOTAL (SUM OF LINES 1-3)				
5				
6				
7				
8	1.00	697		
9				
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	85,364			
TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)				
11				
TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12	85,364			
COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				
13	1.000000			
RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				
14	19,580			
TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)				
15	29,028			
PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				
16	48,608			
TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				
17				
ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	48,608			
SUBTRACT LINE 17 FROM LINE 16				
19	48,608			
OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)				
20	133,972			
TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED 11/24/2009
14-1329	FROM 7/ 1/2008	WORKSHEET M-2
COMPONENT NO:	TO 6/30/2009	
14-3481		

RHC 2

VISITS AND PRODUCTIVITY

GREATER OF
COL. 2 OR
COL. 4
5

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

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

