

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

FORM APPROVED
 OMB NO. 0938-0050

WORKSHEET 5
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	14-1320	I	FROM 1/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/13/2011 TIME 15:23

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

PARIS COMMUNITY HOSPITAL 14-1320
 FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2010 AND ENDING 12/31/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1 HOSPITAL	0		246,505		533,387	0
3 SWING BED - SNF	0		161,376		0	0
9 RHC	0		0		149,433	0
9 .01 RHC II	0		0		10,256	0
9 .02 RHC III	0		0		2,225	0
100 TOTAL	0		407,881		695,301	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: 721 EAST COURT STREET P.O. BOX:
 1.01 CITY: PARIS STATE: IL ZIP CODE: 61944- COUNTY: EDGAR

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

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

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2010 TO: 12/31/2010

18 TYPE OF CONTROL

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL
 20 SUBPROVIDER

OTHER INFORMATION

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

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

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

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

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION (OR APPLICABLE EXTENSION) OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105, MIPPA §147, ACA §3121 OR MMEA §108? "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 IN COL 1 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 OR MMEA §108? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS) N N

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

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

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

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

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

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

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

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

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

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

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

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

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

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?

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

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

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

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

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

25.07 HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THE COST REPORTING PERIOD? ENTER "Y" FOR YES OR "N" FOR NO IN COLUMN 1.

25.08 IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE WEIGHTED NUMBER OF NON-PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. 0.00

IF LINE 25.07 IS YES, USE LINES 25.09 THROUGH 25.59 AS NECESSARY TO IDENTIFY THE PROGRAM NAME IN COLUMN 1, THE PROGRAM CODE IN COLUMN 2, AND THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENTS FTES BY PROGRAM IN COLUMN 3 FOR EACH PRIMARY CARE SPECIALTY PROGRAM IN WHICH RESIDENTS ARE TRAINED. (SEE INSTRUCTIONS)

25.09 0000 0.00

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

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

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

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 6/30/2002

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

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

	1	2	3	4
28.02	0	0.0000	0.0000	
28.02	0.00	0		

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

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

	%	Y/N
28.03 STAFFING	1.00%	Y
28.04 RECRUITMENT	0.00%	
28.05 RETENTION	0.00%	
28.06 TRAINING	0.00%	

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

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

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

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

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

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N
 33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO
 IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO
 YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR
 NO IN COLUMN 2 N
 34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N
 35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
 35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N
 35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?
 35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?
 35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL V XVIII XIX
 1 2 3
 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE
 WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N N
 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?

TITLE XIX INPATIENT SERVICES

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

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

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

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

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

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

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

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00

SETTLEMENT DATA

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

MISCELLANEOUS DATA

64.00 DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. Y

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS / TOTAL TITLE XIX
1 ADULTS & PEDIATRICS	1	25	9,125	34,464.00	3	4	5
2 HMO						1,026	116
2 01 HMO - (IRF PPS SUBPROVIDER)						671	
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	9,125	34,464.00			1,697	116
12 TOTAL	25	9,125	34,464.00			1,697	116
13 RPCH VISITS							
24 RURAL HEALTH CLINIC						9,505	
24 01 RURAL HEALTH CLINIC 2						311	
24 02 RURAL HEALTH CLINIC 3						119	
25 TOTAL	25						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	/ TRIPS / TOTAL OBSERVATION BEDS ADMITTED	NOT ADMITTED	-- INTERNS & RES. FTES -- TOTAL	LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			1,436				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			671				
4 ADULTS & PED-SB NF			3,580				
5 TOTAL ADULTS AND PEDS			5,687				
12 TOTAL			5,687				
13 RPCH VISITS							
24 RURAL HEALTH CLINIC			43,287				
24 01 RURAL HEALTH CLINIC 2			1,932				
24 02 RURAL HEALTH CLINIC 3			907				
25 TOTAL							
26 OBSERVATION BED DAYS			159				
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET	--- FULL TIME EMPLOYEES ON PAYROLL	EQUIV --- NONPAID WORKERS	DISCHARGES TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					303	54	471
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
12 TOTAL		167.25			303	54	471
13 RPCH VISITS							
24 RURAL HEALTH CLINIC		52.20					
24 01 RURAL HEALTH CLINIC 2		2.85					
24 02 RURAL HEALTH CLINIC 3		1.21					
25 TOTAL		223.51					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

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

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

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

FACILITY HOURS OF OPERATIONS (1)

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

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

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

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

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

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

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

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

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

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
12 CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14
			800	1200	1330	1930			800	1200	800	1200		

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

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

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

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

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

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

RHC 3

CLINIC ADDRESS AND IDENTIFICATION

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

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

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

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY			
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO		
12	CLINIC	0		1	2	3	4	5	6	7	8	9	10	11	12	13	14
				830	1200					830	1200	1330	1700				

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

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

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

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

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

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

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET S-10
 I I TO 12/31/2010 I
 I I I

DESCRIPTION

UNCOMPENSATED CARE INFORMATION		
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
UNCOMPENSATED CARE REVENUES		
17	REVENUE FROM UNCOMPENSATED CARE	1,287,998
17.01	GROSS MEDICAID REVENUES	5,616,557
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	6,904,555
UNCOMPENSATED CARE COST		
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.529981
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	5,616,557

HOSPITAL UNCOMPENSATED CARE DATA

IN LIEU OF FORM CMS-2552-96 S-10 (05/2004)
 I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET S-10
 I I TO 12/31/2010 I
 I I I

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	2,976,668
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	2,976,668

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET A
 I I TO 12/31/2010 I

COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
		1	2	3	4	5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		1,078,457	1,078,457	220,411	1,298,868
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		681,531	681,531	156,026	837,557
5	0500 EMPLOYEE BENEFITS	144,114	3,614,137	3,758,251	-270,326	3,487,925
6.01	0660 OTHER ADMINISTRATIVE AND GENERAL	992,750	2,948,379	3,941,129	-147,755	3,793,374
6.02	0661 ADMITTING	496,087	141,888	637,975	-1,239	636,736
8	0800 OPERATION OF PLANT	355,923	577,049	932,972	-1,936	931,036
9	0900 LAUNDRY & LINEN SERVICE		97,907	97,907		97,907
10	1000 HOUSEKEEPING	190,620	43,064	233,684		233,684
11	1100 DIETARY	353,041	168,293	521,334	-286,565	234,769
12	1200 CAFETERIA				286,565	286,565
14	1400 NURSING ADMINISTRATION	446,775	26,073	472,848		472,848
16	1600 PHARMACY	181,650	769,790	951,440	-749,566	201,874
17	1700 MEDICAL RECORDS & LIBRARY	327,682	49,924	377,606		377,606
18	1800 SOCIAL SERVICE		47,918	47,918		47,918
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,309,501	81,132	1,390,633	-15,068	1,375,565
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	561,065	350,060	911,125	-254,279	656,846
40	4000 ANESTHESIOLOGY	481,532	35,103	516,635	125,619	642,254
41	4100 RADIOLOGY-DIAGNOSTIC	1,230,798	955,437	2,186,235	79,837	2,266,072
44	4400 LABORATORY	651,993	696,080	1,348,073	-464	1,347,609
49	4900 RESPIRATORY THERAPY	175,741	28,718	204,459	-34,769	169,690
50	5000 PHYSICAL THERAPY	676,933	80,129	757,062		757,062
53	5300 ELECTROCARDIOLOGY		42,486	42,486	51,850	94,336
54	5400 ELECTROENCEPHALOGRAPHY		105,520	105,520		105,520
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS				292,432	292,432
55.30	5530 IMPL. DEV. CHARGED TO PATIENT				29,914	29,914
56	5600 DRUGS CHARGED TO PATIENTS				813,135	813,135
59	3020 CARDIAC REHAB	87,605	43,245	130,850	-19,429	111,421
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	249,684	46,206	295,890		295,890
60.01	6002 SENIOR CARE		311,358	311,358	-19,717	291,641
61	6100 EMERGENCY	1,053,918	1,406,966	2,460,884		2,460,884
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	3,087,336	609,559	3,696,895	-23,670	3,673,225
63.51	6311 RURAL HEALTH CLINIC 2	187,783	80,289	268,072	-29,668	238,404
63.52	6312 RURAL HEALTH CLINIC 3	104,036	43,684	147,720	-17,097	130,623
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		171,986	171,986	-171,986	
95	SUBTOTALS	13,346,567	15,332,368	28,678,935	12,255	28,691,190
	NONREIMBURS COST CENTERS					
98	9800 PHYSICIANS' PRIVATE OFFICES	912,180	178,916	1,091,096	-12,255	1,078,841
101	TOTAL	14,258,747	15,511,284	29,770,031	-0-	29,770,031

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET A
I I TO 12/31/2010 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	-191,067	1,107,801
4 0400	NEW CAP REL COSTS-MVBLE EQUIP		837,557
5 0500	EMPLOYEE BENEFITS		3,487,925
6.01 0660	OTHER ADMINISTRATIVE AND GENERAL	-125,663	3,667,711
6.02 0661	ADMITTING		636,736
8 0800	OPERATION OF PLANT		931,036
9 0900	LAUNDRY & LINEN SERVICE		97,907
10 1000	HOUSEKEEPING		233,684
11 1100	DIETARY		234,769
12 1200	CAFETERIA	-81,385	205,180
14 1400	NURSING ADMINISTRATION		472,848
16 1600	PHARMACY		201,874
17 1700	MEDICAL RECORDS & LIBRARY	-4,706	372,900
18 1800	SOCIAL SERVICE		47,918
	INPAT ROUTINE SRVC CNTRS		
25 2500	ADULTS & PEDIATRICS	-13,417	1,362,148
	ANCILLARY SRVC COST CNTRS		
37 3700	OPERATING ROOM		656,846
40 4000	ANESTHESIOLOGY	-623,218	19,036
41 4100	RADIOLOGY-DIAGNOSTIC	-749,497	1,516,575
44 4400	LABORATORY		1,347,609
49 4900	RESPIRATORY THERAPY		169,690
50 5000	PHYSICAL THERAPY	-300	756,762
53 5300	ELECTROCARDIOLOGY	-41,086	53,250
54 5400	ELECTROENCEPHALOGRAPHY	-104,503	1,017
55 5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-97	292,335
55.30 5530	IMPL. DEV. CHARGED TO PATIENT		29,914
56 5600	DRUGS CHARGED TO PATIENTS	-36,758	776,377
59 3020	CARDIAC REHAB	-19,482	91,939
	OUTPAT SERVICE COST CNTRS		
60 6000	CLINIC	-17,511	278,379
60.01 6002	SENIOR CARE		291,641
61 6100	EMERGENCY	-1,007,783	1,453,101
62 6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63 4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50 6310	RURAL HEALTH CLINIC	-143,641	3,529,584
63.51 6311	RURAL HEALTH CLINIC 2	-3,319	235,085
63.52 6312	RURAL HEALTH CLINIC 3	-1,179	129,444
	SPEC PURPOSE COST CENTERS		
88 8800	INTEREST EXPENSE		-0-
95	SUBTOTALS	-3,164,612	25,526,578
	NONREIMBURS COST CENTERS		
98 9800	PHYSICIANS' PRIVATE OFFICES	-12,396	1,066,445
101	TOTAL	-3,177,008	26,593,023

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6.01	OTHER ADMINISTRATIVE AND GENERAL	0660	OTHER ADMINISTRATIVE AND GENERAL
6.02	ADMITTING	0661	OTHER ADMINISTRATIVE AND GENERAL
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
25	INPAT ROUTINE SRVC C ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
59	CARDIAC REHAB	3020	ACUPUNCTURE
	OUTPAT SERVICE COST		
60	CLINIC	6000	
60.01	SENIOR CARE	6002	CLINIC
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
63.51	RURAL HEALTH CLINIC 2	6311	RURAL HEALTH CLINIC #####
63.52	RURAL HEALTH CLINIC 3	6312	RURAL HEALTH CLINIC #####
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
98	PHYSICIANS' PRIVATE OFFICES	9800	
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141320	1/ 1/2010	5/13/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1) COST CENTER		LINE NO	SALARY	OTHER
	1	2	3	4	5
1 RENTAL EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4		156,026
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14 CAFETERIA	B	CAFETERIA	12	194,058	92,507
15 EKG	C	ELECTROCARDIOLOGY	53	32,421	
16					
17 PROPERTY INSURANCE	D	NEW CAP REL COSTS-BLDG & FIXT	3		48,425
18 OXYGEN/PATIENT SUPPLIES	E	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		92,611
19					
20 DRUGS	F	DRUGS CHARGED TO PATIENTS	56		813,135
21					
22 TELEPHONE	H	OTHER ADMINISTRATIVE AND GENERAL	6.01		40,055
23					
24					
25					
26 STRESS TEST	I	ELECTROCARDIOLOGY	53	13,008	6,421
27 MED SUPPLIES	J	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		199,821
28		IMPL. DEV. CHARGED TO PATIENT	55.30		29,914
29 INTEREST EXPENSE	K	NEW CAP REL COSTS-BLDG & FIXT	3		171,986
30 ANESTHESIA BENEFITS	L	ANESTHESIOLOGY	40		126,920
31 RADIOLOGY BENEFITS	M	RADIOLOGY-DIAGNOSTIC	41		139,753
32 WOUND CARE BENEFITS	N	RADIOLOGY-DIAGNOSTIC	41		3,653
36 TOTAL RECLASSIFICATIONS				239,487	1,921,227

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141320	FROM 1/ 1/2010	5/13/2011
	TO 12/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	----- DECREASE -----					A-7 REF 10
	CODE (1)	COST CENTER 6	LINE NO 7	SALARY 8	OTHER 9	
1 RENTAL EXPENSE	A	OTHER ADMINISTRATIVE AND GENERAL	6.01		57,834	10
2		ADMITTING	6.02		1,239	
3		OPERATION OF PLANT	8		1,936	
4		ADULTS & PEDIATRICS	25		3,394	
5		OPERATING ROOM	37		24,544	
6		ANESTHESIOLOGY	40		1,301	
7		LABORATORY	44		464	
8		RESPIRATORY THERAPY	49		2,962	
9		SENIOR CARE	60.01		19,717	
10		RURAL HEALTH CLINIC	63.50		7,740	
11		RURAL HEALTH CLINIC 2	63.51		18,834	
12		RURAL HEALTH CLINIC 3	63.52		7,109	
13		PHYSICIANS' PRIVATE OFFICES	98		8,952	
14 CAFETERIA	B	DIETARY	11	194,058	92,507	
15 EKG	C	ADULTS & PEDIATRICS	25	11,674		
16		RESPIRATORY THERAPY	49	20,747		
17 PROPERTY INSURANCE	D	OTHER ADMINISTRATIVE AND GENERAL	6.01		48,425	11
18 OXYGEN/PATIENT SUPPLIES	E	OTHER ADMINISTRATIVE AND GENERAL	6.01		81,551	
19		RESPIRATORY THERAPY	49		11,060	
20 DRUGS	F	PHARMACY	16		749,566	
21		RADIOLOGY-DIAGNOSTIC	41		63,569	
22 TELEPHONE	H	RURAL HEALTH CLINIC	63.50		15,930	
23		RURAL HEALTH CLINIC 2	63.51		10,834	
24		RURAL HEALTH CLINIC 3	63.52		9,988	
25		PHYSICIANS' PRIVATE OFFICES	98		3,303	
26 STRESS TEST	I	CARDIAC REHAB	59	13,008	6,421	
27 MED SUPPLIES	J	OPERATING ROOM	37		229,735	
28						
29 INTEREST EXPENSE	K	INTEREST EXPENSE	88		171,986	11
30 ANESTHESIA BENEFITS	L	EMPLOYEE BENEFITS	5		126,920	
31 RADIOLOGY BENEFITS	M	EMPLOYEE BENEFITS	5		139,753	
32 WOUND CARE BENEFITS	N	EMPLOYEE BENEFITS	5		3,653	
36 TOTAL RECLASSIFICATIONS				239,487	1,921,227	

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141320	FROM 1/ 1/2010	5/13/2011
	TO 12/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : RENTAL EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	156,026
2.00			0
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
8.00			0
9.00			0
10.00			0
11.00			0
12.00			0
13.00			0
TOTAL RECLASSIFICATIONS FOR CODE A			156,026

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
OTHER ADMINISTRATIVE AND GENER	6.01	57,834	
ADMITTING	6.02	1,239	
OPERATION OF PLANT	8	1,936	
ADULTS & PEDIATRICS	25	3,394	
OPERATING ROOM	37	24,544	
ANESTHESIOLOGY	40	1,301	
LABORATORY	44	464	
RESPIRATORY THERAPY	49	2,962	
SENIOR CARE	60.01	19,717	
RURAL HEALTH CLINIC	63.50	7,740	
RURAL HEALTH CLINIC 2	63.51	18,834	
RURAL HEALTH CLINIC 3	63.52	7,109	
PHYSICIANS' PRIVATE OFFICES	98	8,952	
			156,026

RECLASS CODE: B
EXPLANATION : CAFETERIA

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	286,565
TOTAL RECLASSIFICATIONS FOR CODE B			286,565

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
DIETARY	11	286,565	
			286,565

RECLASS CODE: C
EXPLANATION : EKG

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	32,421
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE C			32,421

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADULTS & PEDIATRICS	25	11,674	
RESPIRATORY THERAPY	49	20,747	
			32,421

RECLASS CODE: D
EXPLANATION : PROPERTY INSURANCE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	48,425
TOTAL RECLASSIFICATIONS FOR CODE D			48,425

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
OTHER ADMINISTRATIVE AND GENER	6.01	48,425	
			48,425

RECLASS CODE: E
EXPLANATION : OXYGEN/PATIENT SUPPLIES

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	92,611
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE E			92,611

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
OTHER ADMINISTRATIVE AND GENER	6.01	81,551	
RESPIRATORY THERAPY	49	11,060	
			92,611

RECLASS CODE: F
EXPLANATION : DRUGS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	813,135
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE F			813,135

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
PHARMACY	16	749,566	
RADIOLOGY-DIAGNOSTIC	41	63,569	
			813,135

RECLASS CODE: H
EXPLANATION : TELEPHONE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	OTHER ADMINISTRATIVE AND GENER	6.01	40,055
2.00			0
3.00			0
4.00			0
TOTAL RECLASSIFICATIONS FOR CODE H			40,055

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
RURAL HEALTH CLINIC	63.50	15,930	
RURAL HEALTH CLINIC 2	63.51	10,834	
RURAL HEALTH CLINIC 3	63.52	9,988	
PHYSICIANS' PRIVATE OFFICES	98	3,303	
			40,055

RECLASS CODE: I
EXPLANATION : STRESS TEST

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	19,429
TOTAL RECLASSIFICATIONS FOR CODE I			19,429

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
CARDIAC REHAB	59	19,429	
			19,429

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141320	1/ 1/2010	5/13/2011
	FROM	WORKSHEET A-6
	TO	12/31/2010
		NOT A CMS WORKSHEET

RECLASS CODE: J
EXPLANATION : MED SUPPLIES

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	199,821	OPERATING ROOM	37	229,735
2.00	IMPL. DEV. CHARGED TO PATIENT	29,914			0
TOTAL RECLASSIFICATIONS FOR CODE J		229,735			229,735

RECLASS CODE: K
EXPLANATION : INTEREST EXPENSE

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	171,986	INTEREST EXPENSE	88	171,986
TOTAL RECLASSIFICATIONS FOR CODE K		171,986			171,986

RECLASS CODE: L
EXPLANATION : ANESTHESIA BENEFITS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ANESTHESIOLOGY	126,920	EMPLOYEE BENEFITS	5	126,920
TOTAL RECLASSIFICATIONS FOR CODE L		126,920			126,920

RECLASS CODE: M
EXPLANATION : RADIOLOGY BENEFITS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RADIOLOGY-DIAGNOSTIC	139,753	EMPLOYEE BENEFITS	5	139,753
TOTAL RECLASSIFICATIONS FOR CODE M		139,753			139,753

RECLASS CODE: N
EXPLANATION : WOUND CARE BENEFITS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RADIOLOGY-DIAGNOSTIC	3,653	EMPLOYEE BENEFITS	5	3,653
TOTAL RECLASSIFICATIONS FOR CODE N		3,653			3,653

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	PURCHASES	ACQUISITIONS	TOTAL	DISPOSALS	ENDING	FULLY
	BALANCES		DONATION		AND		BALANCE
	1	2	3	4	5	6	7
1 LAND	34,112	5,048		5,048		39,160	
2 LAND IMPROVEMENTS	1,786,039	29,628		29,628		1,815,667	
3 BUILDINGS & FIXTURE	20,069,295	1,258,917		1,258,917		21,328,212	
4 BUILDING IMPROVEMEN							
5 FIXED EQUIPMENT	8,598,412	812,522		812,522		9,410,934	
6 MOVABLE EQUIPMENT							
7 SUBTOTAL	30,487,858	2,106,115		2,106,115		32,593,973	
8 RECONCILING ITEMS							
9 TOTAL	30,487,858	2,106,115		2,106,115		32,593,973	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS 1	CAPITIALIZED LEASES 2	GROSS ASSETS FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
3	NEW CAP REL COSTS-BL	23,183,039		23,183,039	.711268				
4	NEW CAP REL COSTS-MV	9,410,934		9,410,934	.288732				
5	TOTAL	32,593,973		32,593,973	1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
3	NEW CAP REL COSTS-BL	1,005,629	-118,239	220,411				1,107,801
4	NEW CAP REL COSTS-MV	681,531	156,026					837,557
5	TOTAL	1,687,160	37,787	220,411				1,945,358

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
3	NEW CAP REL COSTS-BL	1,078,457						1,078,457
4	NEW CAP REL COSTS-MV	681,531						681,531
5	TOTAL	1,759,988						1,759,988

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

ADJUSTMENTS TO EXPENSES

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

I PERIOD: I PREPARED 5/13/2011
I FROM 1/ 1/2010 I WORKSHEET A-8
I TO 12/31/2010 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
	1	2	3	4	
1			**COST CENTER DELETED**	1	
2			**COST CENTER DELETED**	2	
3	A	-44,796	NEW CAP REL COSTS-BLDG &	3	10
4			NEW CAP REL COSTS-MVBLE E	4	
5					
6	B	-7,431	OTHER ADMINISTRATIVE AND	6.01	
7					
8					
9					
10					
11					
12	A-8-2	-1,222,745			
13					
14	A-8-1	-6			
15					
16	B	-81,385	CAFETERIA	12	
17	B	-73,443	NEW CAP REL COSTS-BLDG &	3	10
18	B	-97	MEDICAL SUPPLIES CHARGED	55	
19	B	-36,758	DRUGS CHARGED TO PATIENTS	56	
20	B	-4,706	MEDICAL RECORDS & LIBRARY	17	
21					
22					
23					
24					
25	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	A-8-3				
28			**COST CENTER DELETED**	89	
29			**COST CENTER DELETED**	1	
30			**COST CENTER DELETED**	2	
31			NEW CAP REL COSTS-BLDG &	3	
32			NEW CAP REL COSTS-MVBLE E	4	
33			**COST CENTER DELETED**	20	
34					
35	A-8-4		**COST CENTER DELETED**	51	
36	A-8-4		**COST CENTER DELETED**	52	
37	A	-7,708	OTHER ADMINISTRATIVE AND	6.01	
38	A	-48,865	OTHER ADMINISTRATIVE AND	6.01	
39					
40	A	-32,894	RURAL HEALTH CLINIC	63.50	
41	A	-3,319	RURAL HEALTH CLINIC 2	63.51	
42	A	-1,179	RURAL HEALTH CLINIC 3	63.52	
43	A	-2,396	PHYSICIANS' PRIVATE OFFIC	98	
44	A	-496,298	ANESTHESIOLOGY	40	
45	A	-126,920	ANESTHESIOLOGY	40	
46	B	-6,209	OTHER ADMINISTRATIVE AND	6.01	
47	B	-5,700	OTHER ADMINISTRATIVE AND	6.01	
48	A	-10,395	OTHER ADMINISTRATIVE AND	6.01	
49	B	-110,747	RURAL HEALTH CLINIC	63.50	
49.01					
49.02					
49.03	B	-10,000	PHYSICIANS' PRIVATE OFFIC	98	
49.04	A	-2,756	OTHER ADMINISTRATIVE AND	6.01	
49.05	B	-300	PHYSICAL THERAPY	50	
49.06					
49.07	A	-609,738	RADIOLOGY-DIAGNOSTIC	41	
49.08	A	-139,753	RADIOLOGY-DIAGNOSTIC	41	
49.09	A	-13,858	CLINIC	60	
49.10	A	-3,653	CLINIC	60	
49.11	A	-72,828	NEW CAP REL COSTS-BLDG &	3	9
49.12	A	-125	OTHER ADMINISTRATIVE AND	6.01	
49.13					
50		-3,177,008			

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	41	RADIOLOGY-DIAGNOSTIC	DSS MRI	239,778	239,784	-6
2						
3						
4						
5		TOTALS		239,778	239,784	-6

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	A	DSS MRI		100.00	0.00
2				0.00	0.00
3				0.00	0.00
4				0.00	0.00
5				0.00	0.00

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET A-8-2
 I I TO 12/31/2010 I GROUP 1

1	WKSHT A	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
2	LINE NO.	2	3	4	5	6	7	8	9
1	6	1 ADMIN	36,474	36,474					
2	25	ROUTINE	13,417	13,417					
3	53	EKG	41,086	41,086					
4	54	EEG	104,503	104,503					
5	59	CARDIAC	28,482	19,482	9,000				
6	60	1 SENIOR	20,604		20,604				
7	61	ER	1,350,271	1,007,783	342,488				
8									
9									
10									
11									
12									
13									
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16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	1,594,837	1,222,745	372,092				

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I NOT A CMS WORKSHEET
 I I TO 12/31/2010 I

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

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET B
 I I TO 12/31/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG & OSTS-MVBLE E	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	OTHER ADMINIS TRATIVE AND	ADMITTING
	0	3	4	5	6a.00	6.01	6.02
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &	1,107,801	1,107,801					
004 NEW CAP REL COSTS-MVBLE E	837,557		837,557				
005 EMPLOYEE BENEFITS	3,487,925	3,552	2,685	3,494,162			
006 01 OTHER ADMINISTRATIVE AND	3,667,711	247,738	187,305	264,738	4,367,492	4,367,492	
006 02 ADMITTING	636,736	23,520	17,782	132,292	810,330	159,236	969,566
008 OPERATION OF PLANT	931,036	107,969	81,630	94,914	1,215,549	238,865	
009 LAUNDRY & LINEN SERVICE	97,907	9,227	6,976		114,110	22,424	
010 HOUSEKEEPING	233,684	6,486	4,903	50,833	295,906	58,148	
011 DIETARY	234,769	27,689	20,935	42,396	325,789	64,020	
012 CAFETERIA	205,180	13,261	10,026	51,750	280,217	55,065	
014 NURSING ADMINISTRATION	472,848	8,213	6,210	119,142	606,413	119,165	
016 PHARMACY	201,874	7,499	5,670	48,441	263,484	51,777	
017 MEDICAL RECORDS & LIBRARY	372,900	20,306	15,353	87,383	495,942	97,457	
018 SOCIAL SERVICE	47,918	1,602	1,211		50,731	9,969	
025 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	1,362,148	135,629	102,543	346,093	1,946,413	382,486	167,034
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	656,846	59,983	45,350	149,620	911,799	179,176	78,250
040 ANESTHESIOLOGY	19,036	1,235	934		21,205	4,167	
041 RADIOLOGY-DIAGNOSTIC	1,516,575	57,242	43,278	186,824	1,803,919	354,485	154,811
044 LABORATORY	1,347,609	31,453	23,781	173,868	1,576,711	309,836	135,312
049 RESPIRATORY THERAPY	169,690	5,048	3,816	41,738	220,292	43,289	18,905
050 PHYSICAL THERAPY	756,762	42,504	32,135	180,518	1,011,919	198,850	86,842
053 ELECTROCARDIOLOGY	53,250	2,471	1,868	11,710	69,299	13,618	5,947
054 ELECTROENCEPHALOGRAPHY	1,017				1,017	200	87
055 MEDICAL SUPPLIES CHARGED	292,335				292,335	57,446	25,088
055 30 IMPL. DEV. CHARGED TO PAT	29,914				29,914	5,878	2,567
056 DRUGS CHARGED TO PATIENTS	776,377				776,377	152,564	66,628
059 CARDIAC REHAB	91,939	10,375	7,844	19,893	130,051	25,556	11,161
060 OUTPAT SERVICE COST CNTRS							
CLINIC	278,379	29,687	22,445	66,583	397,094	78,032	34,078
060 01 SENIOR CARE	291,641	15,442	11,675		318,758	62,638	27,355
061 EMERGENCY	1,453,101	44,309	33,500	281,049	1,811,959	356,064	155,501
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	3,529,584	142,337	107,614	823,306	4,602,841	904,493	
063 51 RURAL HEALTH CLINIC 2	235,085	14,477	10,945	50,076	310,583	61,032	
063 52 RURAL HEALTH CLINIC 3	129,444	7,460	5,640	27,743	170,287	33,463	
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	25,526,578	1,076,714	814,054	3,250,910	25,228,736	4,099,399	969,566
098 NONREIMBURS COST CENTERS							
PHYSICIANS' PRIVATE OFFIC	1,066,445	31,087	23,503	243,252	1,364,287	268,093	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	26,593,023	1,107,801	837,557	3,494,162	26,593,023	4,367,492	969,566

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY
	8	9	10	11	12	14	16
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 OTHER ADMINISTRATIVE AND							
006 02 ADMITTING							
008 OPERATION OF PLANT	1,454,414						
009 LAUNDRY & LINEN SERVICE	18,509	155,043					
010 HOUSEKEEPING	13,010	40,537	407,601				
011 DIETARY	55,546	1,682	15,912	462,949			
012 CAFETERIA	26,602		7,620		369,504		
014 NURSING ADMINISTRATION	16,476		4,720		12,724	759,498	
016 PHARMACY	15,043		4,309		4,065		338,678
017 MEDICAL RECORDS & LIBRARY	40,735		11,669		17,159		
018 SOCIAL SERVICE	3,214		921				
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	272,076	43,354	77,939	462,949	53,798	403,568	11
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	120,327	11,462	34,469		16,495	123,739	215
040 ANESTHESIOLOGY	2,478		710		4,361		
041 RADIOLOGY-DIAGNOSTIC	114,828	9,293	32,894		27,137		1,984
044 LABORATORY	63,096	746	18,075		29,647		6
049 RESPIRATORY THERAPY	10,126		2,901		6,136		1,533
050 PHYSICAL THERAPY	85,264	21,988	24,425		22,658		282
053 ELECTROCARDIOLOGY	4,956		1,420		1,421		
054 ELECTROENCEPHALOGRAPHY							46
055 MEDICAL SUPPLIES CHARGED							
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS							303,357
059 CARDIAC REHAB	20,813		5,962		2,116		68
OUTPAT SERVICE COST CNTRS							
060 CLINIC	59,553	1,035	17,060		7,548		2,228
060 01 SENIOR CARE	30,977		8,874				
061 EMERGENCY	88,885	22,789	25,462		30,952	232,191	284
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	285,532	2,157	81,789		113,830		26,394
063 51 RURAL HEALTH CLINIC 2	29,041		8,319		6,225		1,034
063 52 RURAL HEALTH CLINIC 3	14,966		4,287		2,647		349
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	1,392,053	155,043	389,737	462,949	358,919	759,498	337,791
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	62,361		17,864		10,585		887
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	1,454,414	155,043	407,601	462,949	369,504	759,498	338,678

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER NO: 14-1320
 I PERIOD: 1/ 1/2010 TO 12/31/2010
 I PREPARED 5/13/2011
 I WORKSHEET B
 I PART I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	18	25	26	27
GENERAL SERVICE COST CNTR					
003 NEW CAP REL COSTS-BLDG &					
004 NEW CAP REL COSTS-MVBLE E					
005 EMPLOYEE BENEFITS					
006 01 OTHER ADMINISTRATIVE AND					
006 02 ADMITTING					
008 OPERATION OF PLANT					
009 LAUNDRY & LINEN SERVICE					
010 HOUSEKEEPING					
011 DIETARY					
012 CAFETERIA					
014 NURSING ADMINISTRATION					
016 PHARMACY					
017 MEDICAL RECORDS & LIBRARY	662,962				
018 SOCIAL SERVICE		64,835			
INPAT ROUTINE SRVC CNTRS					
025 ADULTS & PEDIATRICS	30,764	64,835	3,905,227		3,905,227
ANCILLARY SRVC COST CNTRS					
037 OPERATING ROOM	55,457		1,531,389		1,531,389
040 ANESTHESIOLOGY	7,373		40,294		40,294
041 RADIOLOGY-DIAGNOSTIC	200,490		2,699,841		2,699,841
044 LABORATORY	143,715		2,277,144		2,277,144
049 RESPIRATORY THERAPY	3,482		306,664		306,664
050 PHYSICAL THERAPY	64,955		1,517,183		1,517,183
053 ELECTROCARDIOLOGY	14,031		110,692		110,692
054 ELECTROENCEPHALOGRAPHY	3,210		4,560		4,560
055 MEDICAL SUPPLIES CHARGED	26,688		401,557		401,557
055 30 IMPL. DEV. CHARGED TO PAT			38,359		38,359
056 DRUGS CHARGED TO PATIENTS	49,338		1,348,264		1,348,264
059 CARDIAC REHAB	2,303		198,030		198,030
OUTPAT SERVICE COST CNTRS					
060 CLINIC	5,906		602,534		602,534
060 01 SENIOR CARE	5,753		454,355		454,355
061 EMERGENCY	49,497		2,773,584		2,773,584
062 OBSERVATION BEDS (NON-DIS					
063 OTHER OUTPATIENT SERVICE					
063 50 RURAL HEALTH CLINIC			6,017,036		6,017,036
063 51 RURAL HEALTH CLINIC 2			416,234		416,234
063 52 RURAL HEALTH CLINIC 3			225,999		225,999
SPEC PURPOSE COST CENTERS					
095 SUBTOTALS	662,962	64,835	24,868,946		24,868,946
NONREIMBURS COST CENTERS					
098 PHYSICIANS' PRIVATE OFFIC			1,724,077		1,724,077
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 TOTAL	662,962	64,835	26,593,023		26,593,023

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 14-1320 I PERIOD: 1/ 1/2010 I TO 12/31/2010 I PREPARED 5/13/2011 I WORKSHEET B PART III

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	OTHER ADMINIS TRATIVE AND	ADMITTING
	0	3	4	4a	5	6.01	6.02
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS		3,552	2,685	6,237	6,237		
006 01 OTHER ADMINISTRATIVE AND		247,738	187,305	435,043	473	435,516	
006 02 ADMITTING		23,520	17,782	41,302	236	15,878	57,416
008 OPERATION OF PLANT		107,969	81,630	189,599	169	23,819	
009 LAUNDRY & LINEN SERVICE		9,227	6,976	16,203		2,236	
010 HOUSEKEEPING		6,486	4,903	11,389	91	5,798	
011 DIETARY		27,689	20,935	48,624	76	6,384	
012 CAFETERIA		13,261	10,026	23,287	92	5,491	
014 NURSING ADMINISTRATION		8,213	6,210	14,423	213	11,883	
016 PHARMACY		7,499	5,670	13,169	86	5,163	
017 MEDICAL RECORDS & LIBRARY		20,306	15,353	35,659	156	9,718	
018 SOCIAL SERVICE		1,602	1,211	2,813		994	
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		135,629	102,543	238,172	618	38,140	9,890
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		59,983	45,350	105,333	267	17,867	4,634
040 ANESTHESIOLOGY		1,235	934	2,169		416	
041 RADIOLOGY-DIAGNOSTIC		57,242	43,278	100,520	333	35,348	9,168
044 LABORATORY		31,453	23,781	55,234	310	30,896	8,013
049 RESPIRATORY THERAPY		5,048	3,816	8,864	75	4,317	1,120
050 PHYSICAL THERAPY		42,504	32,135	74,639	322	19,829	5,143
053 ELECTROCARDIOLOGY		2,471	1,868	4,339	21	1,358	352
054 ELECTROENCEPHALOGRAPHY						20	5
055 MEDICAL SUPPLIES CHARGED						5,728	1,486
055 30 IMPL. DEV. CHARGED TO PAT						586	152
056 DRUGS CHARGED TO PATIENTS						15,213	3,946
059 CARDIAC REHAB		10,375	7,844	18,219	36	2,548	661
OUTPAT SERVICE COST CNTRS							
060 CLINIC		29,687	22,445	52,132	119	7,781	2,018
060 01 SENIOR CARE		15,442	11,675	27,117		6,246	1,620
061 EMERGENCY		44,309	33,500	77,809	502	35,505	9,208
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC		142,337	107,614	249,951	1,469	90,198	
063 51 RURAL HEALTH CLINIC 2		14,477	10,945	25,422	89	6,086	
063 52 RURAL HEALTH CLINIC 3		7,460	5,640	13,100	50	3,337	
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		1,076,714	814,054	1,890,768	5,803	408,783	57,416
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC		31,087	23,503	54,590	434	26,733	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		1,107,801	837,557	1,945,358	6,237	435,516	57,416

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 14-1320
 I PERIOD: 1/ 1/2010 TO 12/31/2010
 I PREPARED 5/13/2011
 I WORKSHEET B
 I PART III

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY
	8	9	10	11	12	14	16
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 OTHER ADMINISTRATIVE AND							
006 02 ADMITTING							
008 OPERATION OF PLANT	213,587						
009 LAUNDRY & LINEN SERVICE	2,718	21,157					
010 HOUSEKEEPING	1,911	5,532	24,721				
011 DIETARY	8,157	230		64,436			
012 CAFETERIA	3,907				33,239		
014 NURSING ADMINISTRATION	2,420				1,145	30,370	
016 PHARMACY	2,209				366		21,254
017 MEDICAL RECORDS & LIBRARY	5,982				1,544		
018 SOCIAL SERVICE	472						
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	39,956	5,916	4,727	64,436	4,839	16,137	1
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	17,671	1,564	2,091		1,484	4,948	14
040 ANESTHESIOLOGY	364		43		392		
041 RADIOLOGY-DIAGNOSTIC	16,863	1,268	1,995		2,441		125
044 LABORATORY	9,266	102	1,096		2,667		
049 RESPIRATORY THERAPY	1,487		176		552		96
050 PHYSICAL THERAPY	12,521	3,000	1,481		2,038		18
053 ELECTROCARDIOLOGY	728		86		128		
054 ELECTROENCEPHALOGRAPHY							3
055 MEDICAL SUPPLIES CHARGED							
055 30 IMPL. DEV. CHARGED TO PAT							
056 DRUGS CHARGED TO PATIENTS							19,036
059 CARDIAC REHAB	3,056		362		190		4
OUTPAT SERVICE COST CNTRS							
060 CLINIC	8,746	141	1,035		679		140
060 01 SENIOR CARE	4,549		538				
061 EMERGENCY	13,053	3,110	1,544		2,784	9,285	18
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	41,930	294	4,961		10,240		1,656
063 51 RURAL HEALTH CLINIC 2	4,265		505		560		65
063 52 RURAL HEALTH CLINIC 3	2,198		260		238		22
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	204,429	21,157	23,638	64,436	32,287	30,370	21,198
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	9,158		1,083		952		56
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	213,587	21,157	24,721	64,436	33,239	30,370	21,254

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 14-1320 I PERIOD: 1/ 1/2010 I PREPARED 5/13/2011
 I FROM 1/ 1/2010 I WORKSHEET B
 I TO 12/31/2010 I PART III

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	18	25	26	27
003 GENERAL SERVICE COST CNTR					
004 NEW CAP REL COSTS-BLDG &					
005 NEW CAP REL COSTS-MVBLE E					
006 EMPLOYEE BENEFITS					
006 01 OTHER ADMINISTRATIVE AND					
006 02 ADMITTING					
008 OPERATION OF PLANT					
009 LAUNDRY & LINEN SERVICE					
010 HOUSEKEEPING					
011 DIETARY					
012 CAFETERIA					
014 NURSING ADMINISTRATION					
016 PHARMACY					
017 MEDICAL RECORDS & LIBRARY	53,767				
018 SOCIAL SERVICE		4,335			
025 INPAT ROUTINE SRVC CNTRS					
ADULTS & PEDIATRICS	2,495	4,335	429,662		429,662
037 ANCILLARY SRVC COST CNTRS					
OPERATING ROOM	4,497		160,370		160,370
040 ANESTHESIOLOGY	598		3,982		3,982
041 RADIOLOGY-DIAGNOSTIC	16,263		184,324		184,324
044 LABORATORY	11,655		119,239		119,239
049 RESPIRATORY THERAPY	282		16,969		16,969
050 PHYSICAL THERAPY	5,267		124,258		124,258
053 ELECTROCARDIOLOGY	1,138		8,150		8,150
054 ELECTROENCEPHALOGRAPHY	260		288		288
055 MEDICAL SUPPLIES CHARGED	2,164		9,378		9,378
055 30 IMPL. DEV. CHARGED TO PAT			738		738
056 DRUGS CHARGED TO PATIENTS	4,001		42,196		42,196
059 CARDIAC REHAB	187		25,263		25,263
060 OUTPAT SERVICE COST CNTRS					
CLINIC	479		73,270		73,270
060 01 SENIOR CARE	467		40,537		40,537
061 EMERGENCY	4,014		156,832		156,832
062 OBSERVATION BEDS (NON-DIS					
063 OTHER OUTPATIENT SERVICE					
063 50 RURAL HEALTH CLINIC			400,699		400,699
063 51 RURAL HEALTH CLINIC 2			36,992		36,992
063 52 RURAL HEALTH CLINIC 3			19,205		19,205
095 SPEC PURPOSE COST CENTERS					
SUBTOTALS	53,767	4,335	1,852,352		1,852,352
098 NONREIMBURS COST CENTERS					
PHYSICIANS' PRIVATE OFFIC			93,006		93,006
101 CROSS FOOT ADJUSTMENTS					
102 NEGATIVE COST CENTER					
103 TOTAL	53,767	4,335	1,945,358		1,945,358

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	S RECONCIL-) IATION	OTHER ADMINIS	ADMITTING	COS
	OSTS-BLDG &	OSTS-MVBLE E	FITS		TRATIVÉ AND	(ACCUM.)T	
	(SQUARE FEET	(SQUARE)FEET	(GROSS)ALARIES	6a.01	(ACCUM. COST	(ACCUM.)T)
	3	4	5		6.01	6.02	
003 GENERAL SERVICE COST							
004 NEW CAP REL COSTS-BLD	114,783						
005 NEW CAP REL COSTS-MVB		114,783					
006 01 EMPLOYEE BENEFITS	368	368	13,102,880				
006 02 OTHER ADMINISTRATIVE	25,669	25,669	992,750	-4,367,492	22,225,531		
008 02 ADMITTING	2,437	2,437	496,087		810,330	11,297,857	
009 OPERATION OF PLANT	11,187	11,187	355,923		1,215,549		
010 LAUNDRY & LINEN SERVI	956	956			114,110		
011 HOUSEKEEPING	672	672	190,620		295,906		
012 DIETARY	2,869	2,869	158,983		325,789		
014 CAFETERIA	1,374	1,374	194,058		280,217		
016 NURSING ADMINISTRATIO	851	851	446,775		606,413		
017 PHARMACY	777	777	181,650		263,484		
018 MEDICAL RECORDS & LIB	2,104	2,104	327,682		495,942		
025 SOCIAL SERVICE	166	166			50,731		
025 INPAT ROUTINE SRVC CN							
025 ADULTS & PEDIATRICS	14,053	14,053	1,297,826		1,946,413	1,946,413	
037 ANCILLARY SRVC COST C							
040 OPERATING ROOM	6,215	6,215	561,065		911,799	911,799	
041 ANESTHESIOLOGY	128	128			21,205		
044 RADIOLOGY-DIAGNOSTIC	5,931	5,931	700,578		1,803,919	1,803,919	
049 LABORATORY	3,259	3,259	651,993		1,576,711	1,576,711	
050 RESPIRATORY THERAPY	523	523	156,514		220,292	220,292	
053 PHYSICAL THERAPY	4,404	4,404	676,933		1,011,919	1,011,919	
054 ELECTROCARDIOLOGY	256	256	43,910		69,299	69,299	
055 ELECTROENCEPHALOGRAPH					1,017	1,017	
055 30 MEDICAL SUPPLIES CHAR					292,335	292,335	
056 IMPL. DEV. CHARGED TO					29,914	29,914	
059 DRUGS CHARGED TO PATI					776,377	776,377	
060 CARDIAC REHAB	1,075	1,075	74,596		130,051	130,051	
060 OUTPAT SERVICE COST C							
060 01 CLINIC	3,076	3,076	249,684		397,094	397,094	
061 SENIOR CARE	1,600	1,600			318,758	318,758	
062 EMERGENCY	4,591	4,591	1,053,918		1,811,959	1,811,959	
063 OBSERVATION BEDS (NON							
063 50 OTHER OUTPATIENT SERV							
063 51 RURAL HEALTH CLINIC	14,748	14,748	3,087,336		4,602,841		
063 52 RURAL HEALTH CLINIC 2	1,500	1,500	187,783		310,583		
063 52 RURAL HEALTH CLINIC 3	773	773	104,036		170,287		
095 SPEC PURPOSE COST CEN							
095 SUBTOTALS	111,562	111,562	12,190,700	-4,367,492	20,861,244	11,297,857	
098 NONREIMBURS COST CENT							
101 PHYSICIANS' PRIVATE O	3,221	3,221	912,180		1,364,287		
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	1,107,801	837,557	3,494,162		4,367,492	969,566	
104 (WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER	9.651264		.266671		.196508		
105 (WRKSHT B, PT I)		7.296873				.085819	
105 COST TO BE ALLOCATED							
106 (WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
107 (WRKSHT B, PT II)							
107 COST TO BE ALLOCATED			6,237		435,516	57,416	
108 (WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER			.000476		.019595		.005082
108 (WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY
		(SQUARE FEET)	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	(FTE'S)	(NRSNG FTE'S)	(DRUGS)
		8	9	10	11	12	14	16
003	GENERAL SERVICE COST							
004	NEW CAP REL COSTS-BLD							
005	NEW CAP REL COSTS-MVB							
006	EMPLOYEE BENEFITS							
006	01 OTHER ADMINISTRATIVE							
006	02 ADMITTING							
008	OPERATION OF PLANT	75,122						
009	LAUNDRY & LINEN SERVI	956	25,159					
010	HOUSEKEEPING	672	6,578	73,494				
011	DIETARY	2,869	273	2,869	100			
012	CAFETERIA	1,374		1,374		353,419		
014	NURSING ADMINISTRATIO	851		851		12,170	96,838	
016	PHARMACY	777		777		3,888		836,839
017	MEDICAL RECORDS & LIB	2,104		2,104		16,412		
018	SOCIAL SERVICE	166		166				
025	INPAT ROUTINE SRVC CN							
	ADULTS & PEDIATRICS	14,053	7,035	14,053	100	51,456	51,456	28
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	6,215	1,860	6,215		15,777	15,777	532
040	ANESTHESIOLOGY	128		128		4,171		
041	RADIOLOGY-DIAGNOSTIC	5,931	1,508	5,931		25,956		4,903
044	LABORATORY	3,259	121	3,259		28,356		14
049	RESPIRATORY THERAPY	523		523		5,869		3,787
050	PHYSICAL THERAPY	4,404	3,568	4,404		21,672		696
053	ELECTROCARDIOLOGY	256		256		1,359		
054	ELECTROENCEPHALOGRAPH							113
055	MEDICAL SUPPLIES CHAR							
055	30 IMPL. DEV. CHARGED TO							
056	DRUGS CHARGED TO PATI							749,566
059	CARDIAC REHAB	1,075		1,075		2,024		167
	OUTPAT SERVICE COST C							
060	CLINIC	3,076	168	3,076		7,219		5,506
060	01 SENIOR CARE	1,600		1,600				
061	EMERGENCY	4,591	3,698	4,591		29,605	29,605	701
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063	50 RURAL HEALTH CLINIC	14,748	350	14,748		108,875		65,217
063	51 RURAL HEALTH CLINIC 2	1,500		1,500		5,954		2,554
063	52 RURAL HEALTH CLINIC 3	773		773		2,532		863
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	71,901	25,159	70,273	100	343,295	96,838	834,647
098	NONREIMBURS COST CENT							
101	PHYSICIANS' PRIVATE O	3,221		3,221		10,124		2,192
102	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	1,454,414	155,043	407,601	462,949	369,504	759,498	338,678
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER		6.162526		4,629.490000		7.842975	
	(WRKSHT B, PT I)							
105	COST TO BE ALLOCATED	19.360693		5.546045		1.045513		.404711
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	213,587	21,157	24,721	64,436	33,239	30,370	21,254
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER		.840932		644.360000		.313617	
	(WRKSHT B, PT III)			.336368		.094050		.025398

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET B-1
 I I TO 12/31/2010 I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E
	(GROSS REV)	(PAT DAYS)
	17	18
003 GENERAL SERVICE COST		
004 NEW CAP REL COSTS-BLD		
005 NEW CAP REL COSTS-MVB		
006 EMPLOYEE BENEFITS		
006 01 OTHER ADMINISTRATIVE		
006 02 ADMITTING		
008 OPERATION OF PLANT		
009 LAUNDRY & LINEN SERVI		
010 HOUSEKEEPING		
011 DIETARY		
012 CAFETERIA		
014 NURSING ADMINISTRATIO		
016 PHARMACY		
017 MEDICAL RECORDS & LIB	41,709,632	
018 SOCIAL SERVICE		100
025 INPAT ROUTINE SRVC CN		
ADULTS & PEDIATRICS	1,935,438	100
037 ANCILLARY SRVC COST C		
OPERATING ROOM	3,488,936	
040 ANESTHESIOLOGY	463,834	
041 RADIOLOGY-DIAGNOSTIC	12,614,186	
044 LABORATORY	9,041,552	
049 RESPIRATORY THERAPY	219,074	
050 PHYSICAL THERAPY	4,086,500	
053 ELECTROCARDIOLOGY	882,745	
054 ELECTROENCEPHALOGRAPH	201,938	
055 MEDICAL SUPPLIES CHAR	1,679,009	
055 30 IMPL. DEV. CHARGED TO		
056 DRUGS CHARGED TO PATI	3,104,003	
059 CARDIAC REHAB	144,896	
060 OUTPAT SERVICE COST C		
CLINIC	371,569	
060 01 SENIOR CARE	361,963	
061 EMERGENCY	3,113,989	
062 OBSERVATION BEDS (NON		
063 OTHER OUTPATIENT SERV		
063 50 RURAL HEALTH CLINIC		
063 51 RURAL HEALTH CLINIC 2		
063 52 RURAL HEALTH CLINIC 3		
095 SPEC PURPOSE COST CEN		
SUBTOTALS	41,709,632	100
098 NONREIMBURS COST CENT		
101 PHYSICIANS' PRIVATE O		
102 CROSS FOOT ADJUSTMENT		
103 NEGATIVE COST CENTER		
COST TO BE ALLOCATED	662,962	64,835
(PER WRKSHT B, PART		
104 UNIT COST MULTIPLIER		648.350000
(WRKSHT B, PT I)	.015895	
105 COST TO BE ALLOCATED		
(PER WRKSHT B, PART		
106 UNIT COST MULTIPLIER		
(WRKSHT B, PT II)		
107 COST TO BE ALLOCATED	53,767	4,335
(PER WRKSHT B, PART		
108 UNIT COST MULTIPLIER		43.350000
(WRKSHT B, PT III)	.001289	

COMPUTATION OF RATIO OF COSTS TO CHARGES

PROVIDER NO: 14-1320 I PERIOD: 1/ 1/2010 I PREPARED 5/13/2011
 I FROM 1/ 1/2010 I WORKSHEET C
 I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,905,227		3,905,227		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,531,389		1,531,389		
40	ANESTHESIOLOGY	40,294		40,294		
41	RADIOLOGY-DIAGNOSTIC	2,699,841		2,699,841		
44	LABORATORY	2,277,144		2,277,144		
49	RESPIRATORY THERAPY	306,664		306,664		
50	PHYSICAL THERAPY	1,517,183		1,517,183		
53	ELECTROCARDIOLOGY	110,692		110,692		
54	ELECTROENCEPHALOGRAPHY	4,560		4,560		
55	MEDICAL SUPPLIES CHARGED	401,557		401,557		
55	30 IMPL. DEV. CHARGED TO PAT	38,359		38,359		
56	DRUGS CHARGED TO PATIENTS	1,348,264		1,348,264		
59	CARDIAC REHAB	198,030		198,030		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	602,534		602,534		
60	01 SENIOR CARE	454,355		454,355		
61	EMERGENCY	2,773,584		2,773,584		
62	OBSERVATION BEDS (NON-DIS	245,795		245,795		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	6,017,036		6,017,036		
63	51 RURAL HEALTH CLINIC 2	416,234		416,234		
63	52 RURAL HEALTH CLINIC 3	225,999		225,999		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	25,114,741		25,114,741		
102	LESS OBSERVATION BEDS	245,795		245,795		
103	TOTAL	24,868,946		24,868,946		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS ANCILLARY SRVC COST CNTRS	1,800,215		1,800,215			
37	OPERATING ROOM	257,896	3,231,040	3,488,936	.438927	.438927	
40	ANESTHESIOLOGY	47,654	416,180	463,834	.086872	.086872	
41	RADIOLOGY-DIAGNOSTIC	515,119	12,099,068	12,614,187	.214032	.214032	
44	LABORATORY	533,715	8,507,837	9,041,552	.251853	.251853	
49	RESPIRATORY THERAPY	126,736	92,338	219,074	1.399819	1.399819	
50	PHYSICAL THERAPY	477,846	3,608,653	4,086,499	.371267	.371267	
53	ELECTROCARDIOLOGY	35,000	847,745	882,745	.125395	.125395	
54	ELECTROENCEPHALOGRAPHY	317	201,622	201,939	.022581	.022581	
55	MEDICAL SUPPLIES CHARGED	522,449	1,042,114	1,564,563	.256658	.256658	
55	30 IMPL. DEV. CHARGED TO PAT	1,568	112,878	114,446	.335171	.335171	
56	DRUGS CHARGED TO PATIENTS	906,410	2,197,593	3,104,003	.434363	.434363	
59	CARDIAC REHAB OUTPAT SERVICE COST CNTRS		144,896	144,896	1.366704	1.366704	
60	CLINIC		371,569	371,569	1.621594	1.621594	
60	01 SENIOR CARE		361,963	361,963	1.255253	1.255253	
61	EMERGENCY	58,900	3,055,089	3,113,989	.890685	.890685	
62	OBSERVATION BEDS (NON-DIS	8,717	126,507	135,224	1.817688	1.817688	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		4,886,890	4,886,890	1.231261	1.231261	
63	51 RURAL HEALTH CLINIC 2		231,388	231,388	1.798857	1.798857	
63	52 RURAL HEALTH CLINIC 3		96,296	96,296	2.346920	2.346920	
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	5,292,542	41,631,666	46,924,208			
102	LESS OBSERVATION BEDS						
103	TOTAL	5,292,542	41,631,666	46,924,208			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET C
I I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS ANCILLARY SRVC COST CNTRS	3,905,227		3,905,227		
37	OPERATING ROOM	1,531,389		1,531,389		
40	ANESTHESIOLOGY	40,294		40,294		
41	RADIOLOGY-DIAGNOSTIC	2,699,841		2,699,841		
44	LABORATORY	2,277,144		2,277,144		
49	RESPIRATORY THERAPY	306,664		306,664		
50	PHYSICAL THERAPY	1,517,183		1,517,183		
53	ELECTROCARDIOLOGY	110,692		110,692		
54	ELECTROENCEPHALOGRAPHY	4,560		4,560		
55	MEDICAL SUPPLIES CHARGED	401,557		401,557		
55	30 IMPL. DEV. CHARGED TO PAT	38,359		38,359		
56	DRUGS CHARGED TO PATIENTS	1,348,264		1,348,264		
59	CARDIAC REHAB OUTPAT SERVICE COST CNTRS	198,030		198,030		
60	CLINIC	602,534		602,534		
60	01 SENIOR CARE	454,355		454,355		
61	EMERGENCY	2,773,584		2,773,584		
62	OBSERVATION BEDS (NON-DIS	245,795		245,795		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	6,017,036		6,017,036		
63	51 RURAL HEALTH CLINIC 2	416,234		416,234		
63	52 RURAL HEALTH CLINIC 3	225,999		225,999		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	25,114,741		25,114,741		
102	LESS OBSERVATION BEDS	245,795		245,795		
103	TOTAL	24,868,946		24,868,946		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET C
I TO 12/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	1,800,215		1,800,215			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	257,896	3,231,040	3,488,936	.438927	.438927	
40	ANESTHESIOLOGY	47,654	416,180	463,834	.086872	.086872	
41	RADIOLOGY-DIAGNOSTIC	515,119	12,099,068	12,614,187	.214032	.214032	
44	LABORATORY	533,715	8,507,837	9,041,552	.251853	.251853	
49	RESPIRATORY THERAPY	126,736	92,338	219,074	1.399819	1.399819	
50	PHYSICAL THERAPY	477,846	3,608,653	4,086,499	.371267	.371267	
53	ELECTROCARDIOLOGY	35,000	847,745	882,745	.125395	.125395	
54	ELECTROENCEPHALOGRAPHY	317	201,622	201,939	.022581	.022581	
55	MEDICAL SUPPLIES CHARGED	522,449	1,042,114	1,564,563	.256658	.256658	
55	30 IMPL. DEV. CHARGED TO PAT	1,568	112,878	114,446	.335171	.335171	
56	DRUGS CHARGED TO PATIENTS	906,410	2,197,593	3,104,003	.434363	.434363	
59	CARDIAC REHAB		144,896	144,896	1.366704	1.366704	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		371,569	371,569	1.621594	1.621594	
60	01 SENIOR CARE		361,963	361,963	1.255253	1.255253	
61	EMERGENCY	58,900	3,055,089	3,113,989	.890685	.890685	
62	OBSERVATION BEDS (NON-DIS	8,717	126,507	135,224	1.817688	1.817688	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		4,886,890	4,886,890	1.231261	1.231261	
63	51 RURAL HEALTH CLINIC 2		231,388	231,388	1.798857	1.798857	
63	52 RURAL HEALTH CLINIC 3		96,296	96,296	2.346920	2.346920	
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	5,292,542	41,631,666	46,924,208			
102	LESS OBSERVATION BEDS						
103	TOTAL	5,292,542	41,631,666	46,924,208			

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
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,531,389	160,370	1,371,019			1,531,389
40	ANESTHESIOLOGY	40,294	3,982	36,312			40,294
41	RADIOLOGY-DIAGNOSTIC	2,699,841	184,324	2,515,517			2,699,841
44	LABORATORY	2,277,144	119,239	2,157,905			2,277,144
49	RESPIRATORY THERAPY	306,664	16,969	289,695			306,664
50	PHYSICAL THERAPY	1,517,183	124,258	1,392,925			1,517,183
53	ELECTROCARDIOLOGY	110,692	8,150	102,542			110,692
54	ELECTROENCEPHALOGRAPHY	4,560	288	4,272			4,560
55	MEDICAL SUPPLIES CHARGED	401,557	9,378	392,179			401,557
55	30 IMPL. DEV. CHARGED TO PAT	38,359	738	37,621			38,359
56	DRUGS CHARGED TO PATIENTS	1,348,264	42,196	1,306,068			1,348,264
59	CARDIAC REHAB	198,030	25,263	172,767			198,030
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	602,534	73,270	529,264			602,534
60	01 SENIOR CARE	454,355	40,537	413,818			454,355
61	EMERGENCY	2,773,584	156,832	2,616,752			2,773,584
62	OBSERVATION BEDS (NON-DIS	245,795		245,795			245,795
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	6,017,036	400,699	5,616,337			6,017,036
63	51 RURAL HEALTH CLINIC 2	416,234	36,992	379,242			416,234
63	52 RURAL HEALTH CLINIC 3	225,999	19,205	206,794			225,999
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	21,209,514	1,422,690	19,786,824			21,209,514
102	LESS OBSERVATION BEDS	245,795		245,795			245,795
103	TOTAL	20,963,719	1,422,690	19,541,029			20,963,719

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	3,488,936	.438927	.438927
40	ANESTHESIOLOGY	463,834	.086872	.086872
41	RADIOLOGY-DIAGNOSTIC	12,614,187	.214032	.214032
44	LABORATORY	9,041,552	.251853	.251853
49	RESPIRATORY THERAPY	219,074	1.399819	1.399819
50	PHYSICAL THERAPY	4,086,499	.371267	.371267
53	ELECTROCARDIOLOGY	882,745	.125395	.125395
54	ELECTROENCEPHALOGRAPHY	201,939	.022581	.022581
55	MEDICAL SUPPLIES CHARGED	1,564,563	.256658	.256658
55	30 IMPL. DEV. CHARGED TO PAT	114,446	.335171	.335171
56	DRUGS CHARGED TO PATIENTS	3,104,003	.434363	.434363
59	CARDIAC REHAB	144,896	1.366704	1.366704
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	371,569	1.621594	1.621594
60	01 SENIOR CARE	361,963	1.255253	1.255253
61	EMERGENCY	3,113,989	.890685	.890685
62	OBSERVATION BEDS (NON-DIS	135,224	1.817688	1.817688
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	4,886,890	1.231261	1.231261
63	51 RURAL HEALTH CLINIC 2	231,388	1.798857	1.798857
63	52 RURAL HEALTH CLINIC 3	96,296	2.346920	2.346920
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	45,123,993		
102	LESS OBSERVATION BEDS	135,224		
103	TOTAL	44,988,769		

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
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,531,389	160,370	1,371,019			1,531,389
40	ANESTHESIOLOGY	40,294	3,982	36,312			40,294
41	RADIOLOGY-DIAGNOSTIC	2,699,841	184,324	2,515,517			2,699,841
44	LABORATORY	2,277,144	119,239	2,157,905			2,277,144
49	RESPIRATORY THERAPY	306,664	16,969	289,695			306,664
50	PHYSICAL THERAPY	1,517,183	124,258	1,392,925			1,517,183
53	ELECTROCARDIOLOGY	110,692	8,150	102,542			110,692
54	ELECTROENCEPHALOGRAPHY	4,560	288	4,272			4,560
55	MEDICAL SUPPLIES CHARGED	401,557	9,378	392,179			401,557
55	30 IMPL. DEV. CHARGED TO PAT	38,359	738	37,621			38,359
56	DRUGS CHARGED TO PATIENTS	1,348,264	42,196	1,306,068			1,348,264
59	CARDIAC REHAB	198,030	25,263	172,767			198,030
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	602,534	73,270	529,264			602,534
60	01 SENIOR CARE	454,355	40,537	413,818			454,355
61	EMERGENCY	2,773,584	156,832	2,616,752			2,773,584
62	OBSERVATION BEDS (NON-DIS	245,795		245,795			245,795
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	6,017,036	400,699	5,616,337			6,017,036
63	51 RURAL HEALTH CLINIC 2	416,234	36,992	379,242			416,234
63	52 RURAL HEALTH CLINIC 3	225,999	19,205	206,794			225,999
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	21,209,514	1,422,690	19,786,824			21,209,514
102	LESS OBSERVATION BEDS	245,795		245,795			245,795
103	TOTAL	20,963,719	1,422,690	19,541,029			20,963,719

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGR RATIO	I/P PT B COST TO CHRGR RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	3,488,936	.438927	.438927
40	ANESTHESIOLOGY	463,834	.086872	.086872
41	RADIOLOGY-DIAGNOSTIC	12,614,187	.214032	.214032
44	LABORATORY	9,041,552	.251853	.251853
49	RESPIRATORY THERAPY	219,074	1.399819	1.399819
50	PHYSICAL THERAPY	4,086,499	.371267	.371267
53	ELECTROCARDIOLOGY	882,745	.125395	.125395
54	ELECTROENCEPHALOGRAPHY	201,939	.022581	.022581
55	MEDICAL SUPPLIES CHARGED	1,564,563	.256658	.256658
55	30 IMPL. DEV. CHARGED TO PAT	114,446	.335171	.335171
56	DRUGS CHARGED TO PATIENTS	3,104,003	.434363	.434363
59	CARDIAC REHAB	144,896	1.366704	1.366704
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	371,569	1.621594	1.621594
60	01 SENIOR CARE	361,963	1.255253	1.255253
61	EMERGENCY	3,113,989	.890685	.890685
62	OBSERVATION BEDS (NON-DIS	135,224	1.817688	1.817688
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	4,886,890	1.231261	1.231261
63	51 RURAL HEALTH CLINIC 2	231,388	1.798857	1.798857
63	52 RURAL HEALTH CLINIC 3	96,296	2.346920	2.346920
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	45,123,993		
102	LESS OBSERVATION BEDS	135,224		
103	TOTAL	44,988,769		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET C
 I I TO 12/31/2010 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,517,437	3,198,521			
40	ANESTHESIOLOGY	48,718	413,287			
41	RADIOLOGY-DIAGNOSTIC	2,527,453	11,243,668			
44	LABORATORY	2,129,487	8,477,156			
49	RESPIRATORY THERAPY	285,925	287,117			
50	PHYSICAL THERAPY	1,595,754	3,424,009			
53	ELECTROCARDIOLOGY	106,113	873,738			
54	ELECTROENCEPHALOGRAPHY	5,481	265,220			
55	MEDICAL SUPPLIES CHARGED	404,539	1,676,852			
55	30 IMPL. DEV. CHARGED TO PAT					
56	DRUGS CHARGED TO PATIENTS	1,402,901	4,048,114			
59	CARDIAC REHAB	179,436	159,273			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	515,388	317,878			
60	01 SENIOR CARE					
61	EMERGENCY	2,180,327	2,882,766			
62	OBSERVATION BEDS (NON-DIS	141,008	110,621			
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	6,008,828	4,938,035			
63	51 RURAL HEALTH CLINIC 2	386,554	249,931			
63	52 RURAL HEALTH CLINIC 3	222,033	98,356			
	OTHER REIMBURS COST CNTRS					
101	TOTAL	19,657,382	42,664,542			

COMPUTATION OF OUTPATIENT COST PER VISIT -
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET C
I TO 12/31/2010 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	1,517,437		1,517,437	3,198,521			
40	ANESTHESIOLOGY	48,718		48,718	413,287			
41	RADIOLOGY-DIAGNOSTIC	2,527,453		2,527,453	11,243,668			
44	LABORATORY	2,129,487		2,129,487	8,477,156			
49	RESPIRATORY THERAPY	285,925		285,925	287,117			
50	PHYSICAL THERAPY	1,595,754		1,595,754	3,424,009			
53	ELECTROCARDIOLOGY	106,113	53,710	159,823	873,738			
54	ELECTROENCEPHALOGRAPHY	5,481	101,305	106,786	265,220			
55	MEDICAL SUPPLIES CHARGED	404,539		404,539	1,676,852			
55	30 IMPL. DEV. CHARGED TO PAT							
56	DRUGS CHARGED TO PATIENTS	1,402,901		1,402,901	4,048,114			
59	CARDIAC REHAB	179,436	20,480	199,916	159,273			
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	515,388		515,388	317,878			
60	01 SENIOR CARE							
61	EMERGENCY	2,180,327	901,744	3,082,071	2,882,766			
62	OBSERVATION BEDS (NON-DIS	141,008		141,008	110,621			
63	OTHER OUTPATIENT SERVICE							
63	50 RURAL HEALTH CLINIC							
63	51 RURAL HEALTH CLINIC 2							
63	52 RURAL HEALTH CLINIC 3							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	13,039,967	1,077,239	14,117,206	37,378,220			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

TITLE XVIII, PART B HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory surgical Ctr	Outpatient Radialogy
(A) 37 ANCILLARY SRVC COST CNTRS	1	1.01	1.02	2	3
37 OPERATING ROOM	.438927		.438927		
40 ANESTHESIOLOGY	.086872		.086872		
41 RADIOLOGY-DIAGNOSTIC	.214032		.214032		
44 LABORATORY	.251853		.251853		
49 RESPIRATORY THERAPY	1.399819		1.399819		
50 PHYSICAL THERAPY	.371267		.371267		
53 ELECTROCARDIOLOGY	.125395		.125395		
54 ELECTROENCEPHALOGRAPHY	.022581		.022581		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.256658		.256658		
30 55 IMPL. DEV. CHARGED TO PATIENT	.335171		.335171		
56 DRUGS CHARGED TO PATIENTS	.434363		.434363		
59 CARDIAC REHAB	1.366704		1.366704		
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC	1.621594		1.621594		
60 01 SENIOR CARE	1.255253		1.255253		
61 EMERGENCY	.890685		.890685		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.817688		1.817688		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		1,164,075			
40 ANESTHESIOLOGY		149,840			
41 RADIOLOGY-DIAGNOSTIC		3,633,663			
44 LABORATORY		3,442,571			
49 RESPIRATORY THERAPY		25,084			
50 PHYSICAL THERAPY		1,423,719			
53 ELECTROCARDIOLOGY		316,116			
54 ELECTROENCEPHALOGRAPHY		7,913			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		423,540			
30 IMPL. DEV. CHARGED TO PATIENT		112,878			
56 DRUGS CHARGED TO PATIENTS		1,093,797			
59 CARDIAC REHAB		94,072			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		215,009			
60 01 SENIOR CARE		349,530			
61 EMERGENCY		891,336			
62 OBSERVATION BEDS (NON-DISTINCT PART)		66,483			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
101 SUBTOTAL		13,409,626			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		13,409,626			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

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

Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM		510,944	
40 ANESTHESIOLOGY		13,017	
41 RADIOLOGY-DIAGNOSTIC		777,720	
44 LABORATORY		867,022	
49 RESPIRATORY THERAPY		35,113	
50 PHYSICAL THERAPY		528,580	
53 ELECTROCARDIOLOGY		39,639	
54 ELECTROENCEPHALOGRAPHY		179	
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		108,705	
55 30 IMPL. DEV. CHARGED TO PATIENT		37,833	
56 DRUGS CHARGED TO PATIENTS		475,105	
59 CARDIAC REHAB		128,569	
60 OUTPAT SERVICE COST CNTRS			
60 CLINIC		348,657	
60 01 SENIOR CARE		438,749	
61 EMERGENCY		793,900	
62 OBSERVATION BEDS (NON-DISTINCT PART)		120,845	
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
63 51 RURAL HEALTH CLINIC 2			
63 52 RURAL HEALTH CLINIC 3			
101 SUBTOTAL		5,224,577	
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104 NET CHARGES		5,224,577	

(A) WORKSHEET A LINE NUMBERS

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

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.438927				1
40 ANESTHESIOLOGY	.086872				1
41 RADIOLOGY-DIAGNOSTIC	.214032				1
44 LABORATORY	.251853				1
49 RESPIRATORY THERAPY	1.399819				1
50 PHYSICAL THERAPY	.371267				1
53 ELECTROCARDIOLOGY	.125395				1
54 ELECTROENCEPHALOGRAPHY	.022581				1
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.256658				1
55 30 IMPL. DEV. CHARGED TO PATIENT	.335171				
56 DRUGS CHARGED TO PATIENTS	.434363				1
59 CARDIAC REHAB	1.366704				
OUTPAT SERVICE COST CNTRS					
60 CLINIC	1.621594				1
60 01 SENIOR CARE	1.255253				
61 EMERGENCY	.890685				1
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.817688				1
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC	1.231261				1
63 51 RURAL HEALTH CLINIC 2	1.798857				
63 52 RURAL HEALTH CLINIC 3	2.346920				
101 SUBTOTAL					14
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					14

(A) WORKSHEET A LINE NUMBERS

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

TITLE XIX - O/P

HOSPITAL

Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
(A)	5.01	5.02	5.03	6	7
37					
40					
41					
44					
49					
50					
53					
54					
55					
55 30					
56					
59					
60					
60 01					
61					
62					
63					
63 50					
63 51					
63 52					
101					
102					
103					
104					

TITLE XIX - O/P		HOSPITAL				
		Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
Cost Center Description		8	9	9.01	9.02	9.03
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY		1			
50	PHYSICAL THERAPY					
53	ELECTROCARDIOLOGY					
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
55	30 IMPL. DEV. CHARGED TO PATIENT					
56	DRUGS CHARGED TO PATIENTS					
59	CARDIAC REHAB					
59	OUTPAT SERVICE COST CNTRS					
60	CLINIC		2			
60	01 SENIOR CARE					
61	EMERGENCY		1			
62	OBSERVATION BEDS (NON-DISTINCT PART)		2			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63	50 RURAL HEALTH CLINIC		1			
63	51 RURAL HEALTH CLINIC 2					
63	52 RURAL HEALTH CLINIC 3					
101	SUBTOTAL		7			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS--					
103	PROGRAM ONLY CHARGES					
104	NET CHARGES		7			

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,846
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,595
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,595
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	671
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3,580
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,026
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	671
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	112.36
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	112.36
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,905,227
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	402,249
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,439,541
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,465,686

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,221,583
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,221,583
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.018435
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	765.88
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,465,686

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,545.89
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,586,083
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,586,083

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					529,246

2,115,329

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS) 1,037,292
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS)
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 1,037,292
 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE
 COST REPORTING PERIOD
 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE
 COST REPORTING PERIOD
 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XVIII PART A HOSPITAL OTHER

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

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	159
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,545.88
85	OBSERVATION BED COST	245,795

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 HOSPITAL

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		770,050	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.438927	93,838	41,188
40	ANESTHESIOLOGY	.086872	17,415	1,513
41	RADIOLOGY-DIAGNOSTIC	.214032	242,812	51,970
44	LABORATORY	.251853	305,452	76,929
49	RESPIRATORY THERAPY	1.399819	63,173	88,431
50	PHYSICAL THERAPY	.371267	86,328	32,051
53	ELECTROCARDIOLOGY	.125395	18,702	2,345
54	ELECTROENCEPHALOGRAPHY	.022581		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.256658	193,234	49,595
55	30 IMPL. DEV. CHARGED TO PATIENT	.335171	1,568	526
56	DRUGS CHARGED TO PATIENTS	.434363	423,575	183,985
59	CARDIAC REHAB OUTPAT SERVICE COST CNTRS	1.366704		
60	CLINIC	1.621594		
60	01 SENIOR CARE	1.255253		
61	EMERGENCY	.890685	801	713
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.817688		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
63	51 RURAL HEALTH CLINIC 2			
63	52 RURAL HEALTH CLINIC 3			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		1,446,898	529,246
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,446,898	

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.438927		
40	ANESTHESIOLOGY	.086872		
41	RADIOLOGY-DIAGNOSTIC	.214032	13,144	2,813
44	LABORATORY	.251853	26,194	6,597
49	RESPIRATORY THERAPY	1.399819	17,499	24,495
50	PHYSICAL THERAPY	.371267	301,461	111,923
53	ELECTROCARDIOLOGY	.125395	917	115
54	ELECTROENCEPHALOGRAPHY	.022581		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.256658	43,906	11,269
55	30 IMPL. DEV. CHARGED TO PATIENT	.335171		
56	DRUGS CHARGED TO PATIENTS	.434363	115,287	50,076
59	CARDIAC REHAB OUTPAT SERVICE COST CNTRS	1.366704		
60	CLINIC	1.621594		
60	01 SENIOR CARE	1.255253		
61	EMERGENCY	.890685		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.817688		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
63	51 RURAL HEALTH CLINIC 2			
63	52 RURAL HEALTH CLINIC 3			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		518,408	207,288
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		518,408	

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.438927	1	
40	ANESTHESIOLOGY	.086872	1	
41	RADIOLOGY-DIAGNOSTIC	.214032	1	
44	LABORATORY	.251853	1	
49	RESPIRATORY THERAPY	1.399819	1	1
50	PHYSICAL THERAPY	.371267	1	
53	ELECTROCARDIOLOGY	.125395	1	
54	ELECTROENCEPHALOGRAPHY	.022581		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.256658	1	
55	30 IMPL. DEV. CHARGED TO PATIENT	.335171		
56	DRUGS CHARGED TO PATIENTS	.434363	1	
59	CARDIAC REHAB OUTPAT SERVICE COST CNTRS	1.366704		
60	CLINIC	1.0621594		
60	01 SENIOR CARE	1.255253		
61	EMERGENCY	.890685	1	1
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.817688	1	2
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC	1.231261		
63	51 RURAL HEALTH CLINIC 2	1.798857		
63	52 RURAL HEALTH CLINIC 3	2.346920		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		11	4
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		11	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET E
 I COMPONENT NO: I TO 12/31/2010 I PART B
 I 14-1320 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	5,224,577
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	OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,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)	5,224,577
	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)	5,276,823
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	47,649
18.01	CAH ACTUAL BILLED COINSURANCE	2,003,240
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	3,225,934
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	3,225,934
24	PRIMARY PAYER PAYMENTS	943
25	SUBTOTAL	3,224,991
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	590,052
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	590,052
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	3,815,043
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	3,815,043
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	3,281,656
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	533,387
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION ADJUSTMENT 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)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 14-1320 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B		
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,520,098		2,559,459	
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.		98,438		661,552	
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
ADJUSTMENTS TO PROVIDER	.01	8/13/2010	100,353	8/13/2010	63,982
ADJUSTMENTS TO PROVIDER	.02	8/13/2010	1,539		
ADJUSTMENTS TO PROVIDER	.03				
ADJUSTMENTS TO PROVIDER	.04				
ADJUSTMENTS TO PROVIDER	.05				
ADJUSTMENTS TO PROVIDER	.49				
ADJUSTMENTS TO PROGRAM	.50			8/13/2010	3,337
ADJUSTMENTS TO PROGRAM	.51				
ADJUSTMENTS TO PROGRAM	.52				
ADJUSTMENTS TO PROGRAM	.53				
ADJUSTMENTS TO PROGRAM	.54				
SUBTOTAL	.99		101,892		60,645
4 TOTAL INTERIM PAYMENTS			1,720,428		3,281,656
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)			246,505		533,387
7 TOTAL MEDICARE PROGRAM LIABILITY			1,966,933		3,815,043

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2010 I
 I 14-Z320 I I

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,047,909		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	8/13/2010	22,578		
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		22,578		NONE
4 TOTAL INTERIM PAYMENTS		1,070,487		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		161,376		
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY		1,231,863		

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I
 I COMPONENT NO: I TO 12/31/2010 I WORKSHEET E-2
 I 14-2320 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	1,047,665	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	209,361	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	671	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,257,026	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,257,026	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,257,026	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	25,163	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,231,863	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,231,863	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,070,487	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	161,376	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED
I	14-1320	I	FROM 1/ 1/2010	I	5/13/2011
I	COMPONENT NO:	I	TO 12/31/2010	I	WORKSHEET E-3
I	14-1320	I		I	PART II

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,115,329
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,115,329
5	PRIMARY PAYER PAYMENTS	3,590
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,132,856

COMPUTATION OF LESSER OF COST OR CHARGES

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

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	2,132,856
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	218,332
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,914,524
23	COINSURANCE	
24	SUBTOTAL	1,914,524
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	52,409
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	52,409
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	1,966,933
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	1,966,933
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	1,720,428
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	246,505
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	3,931,799			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	7,259,094			
5 OTHER RECEIVABLES	1,060,482			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,133,871			
7 INVENTORY	601,904			
8 PREPAID EXPENSES	486,231			
9 OTHER CURRENT ASSETS	111,946			
10 DUE FROM OTHER FUNDS	252,930			
11 TOTAL CURRENT ASSETS	9,570,515			
FIXED ASSETS				
12 LAND				
12.01 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	32,593,973			
14.01 LESS ACCUMULATED DEPRECIATION	-17,012,471			
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT				
18.01 LESS ACCUMULATED DEPRECIATION				
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	15,581,502			
OTHER ASSETS				
22 INVESTMENTS	11,315,556			
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS	271,147			
25 OTHER ASSETS	171,621			
26 TOTAL OTHER ASSETS	11,758,324			
27 TOTAL ASSETS	36,910,341			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I
 I I TO 12/31/2010 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	828,626			
29 SALARIES, WAGES & FEES PAYABLE	1,338,338			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	270,932			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	165,001			
36 TOTAL CURRENT LIABILITIES	2,602,897			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE	4,131,521			
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	4,131,521			
43 TOTAL LIABILITIES	6,734,418			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	30,175,923			
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	30,175,923			
52 TOTAL LIABILITIES AND FUND BALANCES	36,910,341			

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		28,520,724		
2	NET INCOME (LOSS)		1,582,664		
3	TOTAL		30,103,388		
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5	ADDITIONS (CREDIT ADJUSTM	72,535			
6					
7					
8					
9					
10	TOTAL ADDITIONS		72,535		
11	SUBTOTAL		30,175,923		
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		30,175,923		

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

PROVIDER NO: 14-1320
 I PERIOD: 1/ 1/2010 TO 12/31/2010
 PREPARED 5/13/2011
 WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	1,221,583		1,221,583
4 00 SWING BED - SNF	713,855		713,855
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	1,935,438		1,935,438
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	1,935,438		1,935,438
17 00 ANCILLARY SERVICES	3,483,609	35,557,052	39,040,661
18 00 OUTPATIENT SERVICES		733,532	733,532
18 50 RURAL HEALTH CLINIC		5,467,148	5,467,148
18 51 RURAL HEALTH CLINIC 2		230,814	230,814
18 52 RURAL HEALTH CLINIC 3		96,057	96,057
24 00	381,831	8,532,713	8,914,544
25 00 TOTAL PATIENT REVENUES	5,800,878	50,617,316	56,418,194

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		29,770,031	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)	3,881,012		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		3,881,012	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		33,651,043	

STATEMENT OF REVENUES AND EXPENSES

PROVIDER NO: 14-1320
 PERIOD: FROM 1/1/2010 TO 12/31/2010
 PREPARED 5/13/2011
 WORKSHEET G-3

DESCRIPTION		
1	TOTAL PATIENT REVENUES	56,418,194
2	LESS: ALLOWANCES AND DISCOUNTS ON	23,053,713
3	NET PATIENT REVENUES	33,364,481
4	LESS: TOTAL OPERATING EXPENSES	33,651,043
5	NET INCOME FROM SERVICE TO PATIENT	-286,562
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	NON OPERATING REVENUE	1,485,153
24.01	OTHER REVENUE	384,073
24.02		
25	TOTAL OTHER INCOME	1,869,226
26	TOTAL	1,582,664
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	1,582,664

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

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 14-3987 I I

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2	1,584,865		1,584,865	
3	133,479		133,479	
4				
5	639,511		639,511	
6				
7				
8	543		543	
9				
10	2,358,398		2,358,398	
COSTS UNDER AGREEMENT				
11				
12				
13				
14				
OTHER HEALTH CARE COSTS				
15		3,528	3,528	
16				
17				
18		102,707	102,707	
19				
20				
21		106,235	106,235	
22	2,358,398	106,235	2,464,633	
COSTS OTHER THAN RHC/FQHC SERVICES				
23		65,217	65,217	
24				
25				
26		166,763	166,763	
27				
28		231,980	231,980	
FACILITY OVERHEAD				
29				
30	728,938	271,344	1,000,282	-23,670
31	728,938	271,344	1,000,282	-23,670
32	3,087,336	609,559	3,696,895	-23,670

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

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 14-3987 I I

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	1,584,865		1,584,865
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	133,479		133,479
5 VISITING NURSE			
6 OTHER NURSE	639,511		639,511
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN	543		543
10 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	2,358,398		2,358,398
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT			
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	3,528		3,528
17 TRANSPORTATION (HEALTH CARE STAFF)			
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE	102,707		102,707
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	106,235		106,235
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,464,633		2,464,633
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY	65,217		65,217
25 DENTAL			
26 OPTOMETRY			
26 ALL OTHER NONREIMBURSABLE COSTS	166,763		166,763
27 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	231,980		231,980
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	976,612	-143,641	832,971
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	976,612	-143,641	832,971
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	3,673,225	-143,641	3,529,584

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

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 14-3989 I I

RHC 2

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
1	12,938		12,938	
2				
3	104,423		104,423	
4				
5	37,439		37,439	
6				
7				
8	58		58	
9				
10	154,858		154,858	
COSTS UNDER AGREEMENT				
11				
12				
13				
14				
OTHER HEALTH CARE COSTS				
15		138	138	
16				
17				
18		565	565	
19				
20				
21		703	703	
22	154,858	703	155,561	
COSTS OTHER THAN RHC/FQHC SERVICES				
23		2,554	2,554	
24				
25				
26		16,664	16,664	
27				
28		19,218	19,218	
FACILITY OVERHEAD				
29				
30	32,925	60,368	93,293	-29,668
31	32,925	60,368	93,293	-29,668
32	187,783	80,289	268,072	-29,668

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

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 14-3989 I I

RHC 2

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	12,938		12,938
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	104,423		104,423
5 VISITING NURSE			
6 OTHER NURSE	37,439		37,439
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN	58		58
10 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	154,858		154,858
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT			
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	138		138
17 TRANSPORTATION (HEALTH CARE STAFF)			
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE	565		565
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	703		703
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	155,561		155,561
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY	2,554		2,554
25 DENTAL			
26 OPTOMETRY			
27 ALL OTHER NONREIMBURSABLE COSTS	16,664		16,664
28 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	19,218		19,218
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	63,625	-3,319	60,306
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	63,625	-3,319	60,306
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	238,404	-3,319	235,085

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

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 14-3431 I I

RHC 3

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
1	8,465		8,465	
2				
3	57,006		57,006	
4				
5	21,525		21,525	
6				
7				
8	22		22	
9				
10	87,018		87,018	
COSTS UNDER AGREEMENT				
11				
12				
13				
14				
OTHER HEALTH CARE COSTS				
15		47	47	
16				
17				
18		605	605	
19				
20				
21		652	652	
22	87,018	652	87,670	
COSTS OTHER THAN RHC/FQHC SERVICES				
23		863	863	
24				
25				
26		6,155	6,155	
27				
28		7,018	7,018	
FACILITY OVERHEAD				
29				
30	17,018	36,014	53,032	-17,097
31	17,018	36,014	53,032	-17,097
32	104,036	43,684	147,720	-17,097

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

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-1
I COMPONENT NO: I TO 12/31/2010 I
I 14-3431 I I

RHC 3

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	8,465		8,465
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	57,006		57,006
5 VISITING NURSE			
6 OTHER NURSE	21,525		21,525
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN	22		22
10 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	87,018		87,018
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT			
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	47		47
17 TRANSPORTATION (HEALTH CARE STAFF)			
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE	605		605
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	652		652
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	87,670		87,670
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY	863		863
25 DENTAL			
26 OPTOMETRY			
27 ALL OTHER NONREIMBURSABLE COSTS	6,155		6,155
28 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	7,018		7,018
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	35,935	-1,179	34,756
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	35,935	-1,179	34,756
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	130,623	-1,179	129,444

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-2
I COMPONENT NO: I TO 12/31/2010 I
I 14-3987 I I

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS	3.87	4,200	16,254
2	PHYSICIAN ASSISTANTS		2,100	
3	NURSE PRACTITIONERS	.90	2,100	1,890
4	SUBTOTAL (SUM OF LINES 1-3)	4.77	43,287	18,144
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	4.77	43,287	
9	PHYSICIAN SERVICES UNDER AGREEMENTS			
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	2,464,633		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	231,980		
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	2,696,613		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	.913974		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	832,971		
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	2,487,452		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	3,320,423		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	3,320,423		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	3,034,780		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	5,499,413		
	GREATER OF COL. 2 OR COL. 4 5			
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	43,287		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	43,287		
9	PHYSICIAN SERVICES UNDER AGREEMENTS			

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

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/13/2011	
I	14-1320	I	FROM	I	1/ 1/2010	I	WORKSHEET M-2
I	COMPONENT NO:	I	TO	I	12/31/2010	I	
I	14-3989	I		I		I	

RHC 2

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
1	POSITIONS			
1	PHYSICIANS	.01	1	4,200
2	PHYSICIAN ASSISTANTS			2,100
3	NURSE PRACTITIONERS	.72	1,931	2,100
4	SUBTOTAL (SUM OF LINES 1-3)	.73	1,932	1,512
5	VISITING NURSE			1,554
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	.73	1,932	
9	PHYSICIAN SERVICES UNDER AGREEMENTS			
10	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	155,561		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	19,218		
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	174,779		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	.890044		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	60,306		
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	181,149		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	241,455		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	241,455		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	214,906		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	370,467		
	GREATER OF COL. 2 OR COL. 4 5			
1	POSITIONS			
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	1,932		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	1,932		
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.

RHC 3

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS	.01	3	4,200
2	PHYSICIAN ASSISTANTS			2,100
3	NURSE PRACTITIONERS	.52	904	2,100
4	SUBTOTAL (SUM OF LINES 1-3)	.53	907	1,092
5	VISITING NURSE			1,134
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	.53	907	
9	PHYSICIAN SERVICES UNDER AGREEMENTS			
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	87,670		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	7,018		
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	94,688		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	.925883		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	34,756		
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	96,555		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	131,311		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	131,311		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	121,579		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	209,249		
		GREATER OF COL. 2 OR COL. 4		
		5		
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	1,134		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	1,134		
9	PHYSICIAN SERVICES UNDER AGREEMENTS			

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED
I	14-1320	I	FROM 1/ 1/2010	I	5/13/2011
I	COMPONENT NO:	I	TO 12/31/2010	I	WORKSHEET M-3
I	14-3987	I		I	

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	5,499,413
	(FROM WORKSHEET M-2, LINE 20)	
2	COST OF VACCINES AND THEIR ADMINISTRATION	26,878
	(FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	5,472,535
	(LINE 1 MINUS LINE 2)	
4	TOTAL VISITS	43,287
	(FROM WORKSHEET M-2, COLUMN 5, LINE 8)	
5	PHYSICIANS VISITS UNDER AGREEMENT	
	(FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	43,287
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	126.42

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	126.42
10	CALCULATION OF SETTLEMENT	
	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	9,505
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	1,201,622
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)	
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)	
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)	
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*	1,201,622
16.01	PRIMARY PAYER AMOUNT	
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	120,511
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	1,081,111
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	864,889
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	14,904
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	879,793
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	64,283
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	944,076
25	INTERIM PAYMENTS	794,643
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	149,433
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2	

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
 FOR RHC/FQHC SERVICES

TITLE XVIII RHC 2

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES	UCATION PASS THROUGH COST.
1 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	370,467
2 COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	1,447
3 TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	369,020
4 TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	1,932
5 PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6 TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	1,932
7 ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	191.00

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8 PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)		999.00
9 RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	191.00	191.00
10 CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		311
11 PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		59,401
12 PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13 PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14 LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15 GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16 TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		59,401
16.01 PRIMARY PAYER AMOUNT		
17 LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		6,251
18 NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		53,150
19 REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		42,520
20 PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		858
21 TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		43,378
22 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		1,055
22.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23 OTHER ADJUSTMENTS (SPECIFY)		
24 NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		44,433
25 INTERIM PAYMENTS		34,177
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		10,256
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

COMPUTATION OF PNEUMOCOCCAL AND
INFLUENZA VACCINE COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/13/2011
I	14-1320	I	FROM 1/ 1/2010	I	WORKSHEET	M-4
I	COMPONENT NO:	I	TO 12/31/2010	I		
I	14-3987	I		I		

TITLE XVIII

RHC 1

	PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	2,358,398	2,358,398	2,358,398	2,358,398
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000067	.001823		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	158	4,299		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	2,701	4,293		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	2,859	8,592		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	2,464,633	2,464,633	2,464,633	2,464,633
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	3,320,423	3,320,423	3,320,423	3,320,423
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.001160	.003486		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	3,852	11,575		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	6,711	20,167		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	73	428		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	91.93	47.12		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	35	248		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	3,218	11,686		
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		26,878		
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		14,904		

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-4
 I COMPONENT NO: I TO 12/31/2010 I
 I 14-3989 I I

TITLE XVIII

RHC 2

	PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	154,858	154,858	154,858	154,858
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000049	.000452		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	8	70		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	37	452		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	45	522		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	155,561	155,561	155,561	155,561
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	241,455	241,455	241,455	241,455
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000289	.003356		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	70	810		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	115	1,332		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	1	45		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	115.00	29.60		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		29		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)		858		
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		1,447		
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		858		

COMPUTATION OF PNEUMOCOCCAL AND
INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-4
I COMPONENT NO: I TO 12/31/2010 I
I 14-3431 I I

TITLE XVIII

RHC 3

	PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	87,018	87,018	87,018	87,018
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000025	.001137		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	2	99		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	111	202		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	113	301		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	87,670	87,670	87,670	87,670
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	131,311	131,311	131,311	131,311
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.001289	.003433		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	169	451		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	282	752		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	3	20		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	94.00	37.60		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		12		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)		451		
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		1,034		
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		451		

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

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-5
 I COMPONENT NO: I TO 12/31/2010 I
 I 14-3987 I

RHC 1

DESCRIPTION	P A R T		AMOUNT
	MM/DD/YYYY	B	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1	2
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
ADJUSTMENTS TO PROVIDER .01	8/13/2010		1,573
ADJUSTMENTS TO PROVIDER .02			
ADJUSTMENTS TO PROVIDER .03			
ADJUSTMENTS TO PROVIDER .04			
ADJUSTMENTS TO PROVIDER .05			
ADJUSTMENTS TO PROGRAM .50			
ADJUSTMENTS TO PROGRAM .51			
ADJUSTMENTS TO PROGRAM .52			
ADJUSTMENTS TO PROGRAM .53			
ADJUSTMENTS TO PROGRAM .54			
SUBTOTAL			1,573
4 TOTAL INTERIM PAYMENTS			794,643
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			NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			149,433
SETTLEMENT TO PROVIDER .01			
SETTLEMENT TO PROGRAM .02			
7 TOTAL MEDICARE PROGRAM LIABILITY			944,076

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

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

I PROVIDER NO: I PERIOD: I PREPARED 5/13/2011
 I 14-1320 I FROM 1/ 1/2010 I WORKSHEET M-5
 I COMPONENT NO: I TO 12/31/2010 I
 I 14-3989 I

RHC 2

DESCRIPTION	P A R T	
	MM/DD/YYYY	B AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2
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.		31,406
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)		NONE
ADJUSTMENTS TO PROVIDER .01	8/13/2010	2,771
ADJUSTMENTS TO PROVIDER .02		
ADJUSTMENTS TO PROVIDER .03		
ADJUSTMENTS TO PROVIDER .04		
ADJUSTMENTS TO PROVIDER .05		
ADJUSTMENTS TO PROGRAM .50		
ADJUSTMENTS TO PROGRAM .51		
ADJUSTMENTS TO PROGRAM .52		
ADJUSTMENTS TO PROGRAM .53		
ADJUSTMENTS TO PROGRAM .54		
SUBTOTAL .99		2,771
4 TOTAL INTERIM PAYMENTS		34,177
TO BE COMPLETED BY INTERMEDIARY		
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)		
TENTATIVE TO PROVIDER .01		
TENTATIVE TO PROVIDER .02		
TENTATIVE TO PROVIDER .03		
TENTATIVE TO PROGRAM .50		
TENTATIVE TO PROGRAM .51		
TENTATIVE TO PROGRAM .52		
TENTATIVE TO PROGRAM .52		
TENTATIVE TO PROGRAM .52		
SUBTOTAL .99		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		10,256
SETTLEMENT TO PROVIDER .01		
SETTLEMENT TO PROGRAM .02		
7 TOTAL MEDICARE PROGRAM LIABILITY		44,433

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

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

I PROVIDER NO: 14-1320
 I PERIOD: FROM 1/ 1/2010 TO 12/31/2010
 I COMPONENT NO: 14-3431
 I PREPARED 5/13/2011
 I WORKSHEET M-5
 I

RHC 3

DESCRIPTION		P A R T	
		MM/DD/YYYY	B AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER			2
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.			14,793
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			NONE
ADJUSTMENTS TO PROVIDER	.01	8/13/2010	152
ADJUSTMENTS TO PROVIDER	.02		
ADJUSTMENTS TO PROVIDER	.03		
ADJUSTMENTS TO PROVIDER	.04		
ADJUSTMENTS TO PROVIDER	.05		
ADJUSTMENTS TO PROGRAM	.50		
ADJUSTMENTS TO PROGRAM	.51		
ADJUSTMENTS TO PROGRAM	.52		
ADJUSTMENTS TO PROGRAM	.53		
ADJUSTMENTS TO PROGRAM	.54		
SUBTOTAL	.99		152
4 TOTAL INTERIM PAYMENTS			14,945
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
TENTATIVE TO PROVIDER	.01		
TENTATIVE TO PROVIDER	.02		
TENTATIVE TO PROVIDER	.03		
TENTATIVE TO PROGRAM	.50		
TENTATIVE TO PROGRAM	.51		
TENTATIVE TO PROGRAM	.52		
SUBTOTAL	.99		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			2,225
SETTLEMENT TO PROVIDER	.01		
SETTLEMENT TO PROGRAM	.02		
7 TOTAL MEDICARE PROGRAM LIABILITY			17,170

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.