

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

FORM APPROVED OMB NO. 0938-0050

WORKSHEET S PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX | PROVIDER NO: 14-1300 | PERIOD FROM 9/1/2009 TO 8/31/2010 | INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS | DATE RECEIVED: / / | INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 2/14/2011 TIME 11:26

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: THOMAS H BOYD CRITICAL ACC HOSPITAL 14-1300 FOR THE COST REPORTING PERIOD BEGINNING 9/1/2009 AND ENDING 8/31/2010 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

Table with 4 columns: TITLE V, TITLE XVIII (A, B), TITLE XIX. Rows include HOSPITAL, SWING BED - SNF, RHC, RHC II, RHC III, RHC IV, and TOTAL.

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: 800 SCHOOL STREET P.O. BOX:
 1.01 CITY: CARROLLTON STATE: IL ZIP CODE: 62016- COUNTY: GREENE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O OR N)		
					V	XVII	XIX
02.00 HOSPITAL	THOMAS H BOYD CRITICAL ACC HOSPITAL	14-1300	2.01	7/12/1999	4	5	6
04.00 SWING BED - SNF	THOMAS H BOYD CRITICAL ACC SWING BED	14-Z300		7/12/1999	N	0	0
14.00 HOSPITAL-BASED RHC	GREENE COUNTY RHC	14-3403		6/22/1995	N	0	N
14.01 HOSPITAL-BASED RHC 2	T.H. BOYD RHC	14-3475		10/2/2005	N	0	N
14.02 HOSPITAL-BASED RHC 3	BOYD-FILLAGER GREENFIELD RHC	14-3474		10/3/2005	N	0	N
14.03 HOSPITAL-BASED RHC 4	RHC OF ROODHOUSE	14-3476		10/4/2005	N	0	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 9/1/2009 TO: 8/31/2010

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.
- 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.
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA \$5105 OR MIPPA \$147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO.
- 21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA \$147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS). IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS)
- 21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER?
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.
- 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.
- 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY)
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).

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

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-1, CHAPTER 4?

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

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N

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

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

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

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 7/12/1999

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
	0	0.0000	0.0000	

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

	0.00	0		
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A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

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

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

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

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

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

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

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

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

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

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

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

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

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 505 S MAIN
 1.01 CITY: WHITE HALL STATE: IL ZIP CODE: 62092 COUNTY: GREENE
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
	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	1700	800	1700	800	1700	800	1700	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. N

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVII I TITLE XIX

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

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. N

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 800 SCHOOL STREET
 1.01 CITY: CARROLLTON STATE: IL ZIP CODE: 62016 COUNTY: GREENE
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
	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	700	2100	700	2100	700	2100	700	2100	700	2100	700	2100	700	2100

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVII I TITLE XIX

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

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. N

RHC 3

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 712 COLLEGE ST
 1.01 CITY: GREENFIELD STATE: IL ZIP CODE: 62044 COUNTY: GREENE
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
	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	1700	800	1700	800	1700	800	1700	800	1700		

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVII I TITLE XIX

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

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. N

RHC 4

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 132 W LORTON
 1.01 CITY: ROODHOUSE STATE: IL ZIP CODE: 62082 COUNTY: GREENE
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

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

FACILITY HOURS OF OPERATIONS (1)

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

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVII I TITLE XIX

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

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. N

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
1	0100 OLD CAP REL COSTS-BLDG & FIXT					
2	0200 OLD CAP REL COSTS-MVBLE EQUIP					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		164,402	164,402	-81,937	82,465
4	0400 NEW CAP REL COSTS-MVBLE EQUIP				406,669	406,669
5	0500 EMPLOYEE BENEFITS		422,785	422,785	125,648	548,433
6	0600 ADMINISTRATIVE & GENERAL	632,802	646,744	1,279,546	-5,298	1,274,248
8	0800 OPERATION OF PLANT	51,879	171,239	223,118	10,782	233,900
9	0900 LAUNDRY & LINEN SERVICE	24,500	8,106	32,606		32,606
10	1000 HOUSEKEEPING	60,525	32,297	92,822	7,123	99,945
11	1100 DIETARY	143,276	76,269	219,545		219,545
12	1200 CAFETERIA					
14	1400 NURSING ADMINISTRATION	35,944	4,594	40,538	97,881	138,419
15	1500 CENTRAL SERVICES & SUPPLY					
16	1600 PHARMACY					
17	1700 MEDICAL RECORDS & LIBRARY	140,053	17,221	157,274		157,274
24	2400 PARAMED ED PRGM					
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,157,240	185,423	1,342,663	-28,629	1,314,034
31	3100 SUBPROVIDER					
35	3500 NURSING FACILITY					
	ANCILLARY SRVC COST CNTRS					
41	4100 RADIOLOGY-DIAGNOSTIC	336,300	385,887	722,187	-194,820	527,367
44	4400 LABORATORY	231,997	330,090	562,087	-50,303	511,784
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	4700 BLOOD STORING, PROCESSING & TRANS.		15,405	15,405	2,013	17,418
48	4800 INTRAVENOUS THERAPY					
50	5000 PHYSICAL THERAPY	135,845	29,056	164,901		164,901
53	5300 ELECTROCARDIOLOGY		29,383	29,383	13,420	42,803
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,049	72,175	91,224		91,224
55.30	5530 IMPL. DEV. CHARGED TO PATIENT					
56	5600 DRUGS CHARGED TO PATIENTS		312,218	312,218		312,218
59	3950 OTHER ANCILLARY SERVICE COST CENTERS					
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	6,820	487	7,307		7,307
61	6100 EMERGENCY	845,501	380,314	1,225,815	-39,546	1,186,269
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	133,870	38,469	172,339	-36,411	135,928
63.51	6311 RURAL HEALTH CLINIC 2	383,173	34,860	418,033	-74,808	343,225
63.52	6312 RURAL HEALTH CLINIC 3	269,603	40,954	310,557	-48,477	262,080
63.53	6313 RURAL HEALTH CLINIC 4	176,500	44,374	220,874	-5,701	215,173
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES	426,213	119,722	545,935		545,935
68	5950 OTHER REIMBURSABLE COST CENTERS					
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		68,871	68,871	-68,871	
89	8900 UTILIZATION REVIEW-SNF					
90	9000 OTHER CAPITAL RELATED COSTS		28,735	28,735	-28,735	
92	9200 AMBULATORY SURGICAL CENTER (D.P.)					
94	6950 OTHER SPECIAL PURPOSE (SPECIFY)					
95	SUBTOTALS	5,211,090	3,660,080	8,871,170	-0-	8,871,170
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
97	9700 RESEARCH					
98	9800 PHYSICIANS' PRIVATE OFFICES	44,070	1,475	45,545		45,545
98.01	9801 JAIL MEALS					
98.02	9802 OUTPATIENT MEALS					
98.03	9803 IDLE SPACE					
99	9900 NONPAID WORKERS					
100	7950 OTHER NONREIMBURSABLE COST CENTERS					
101	TOTAL	5,255,160	3,661,555	8,916,715	-0-	8,916,715

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

PROVIDER NO: 14-1300
PERIOD: FROM 9/1/2009 TO 8/31/2010
PREPARED 2/14/2011
WORKSHEET A

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
1	0100 OLD CAP REL COSTS-BLDG & FIXT		
2	0200 OLD CAP REL COSTS-MVBLE EQUIP		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-5,757	76,708
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-1,904	404,765
5	0500 EMPLOYEE BENEFITS	4,286	552,719
6	0600 ADMINISTRATIVE & GENERAL	-53,479	1,220,769
8	0800 OPERATION OF PLANT		233,900
9	0900 LAUNDRY & LINEN SERVICE		32,606
10	1000 HOUSEKEEPING		99,945
11	1100 DIETARY	-36,382	183,163
12	1200 CAFETERIA		
14	1400 NURSING ADMINISTRATION		138,419
15	1500 CENTRAL SERVICES & SUPPLY		
16	1600 PHARMACY		
17	1700 MEDICAL RECORDS & LIBRARY	-3,718	153,556
24	2400 PARAMED ED PRGM		
25	2500 INPAT ROUTINE SRVC CNTRS		
	ADULTS & PEDIATRICS		1,314,034
31	3100 SUBPROVIDER		
35	3500 NURSING FACILITY		
	ANCILLARY SRVC COST CNTRS		
41	4100 RADIOLOGY-DIAGNOSTIC	-335	527,032
44	4400 LABORATORY	-100	511,684
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		
47	4700 BLOOD STORING, PROCESSING & TRANS.		17,418
48	4800 INTRAVENOUS THERAPY		
50	5000 PHYSICAL THERAPY		164,901
53	5300 ELECTROCARDIOLOGY		42,803
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-65	91,159
55.30	5530 IMPL. DEV. CHARGED TO PATIENT		
56	5600 DRUGS CHARGED TO PATIENTS		312,218
59	3950 OTHER ANCILLARY SERVICE COST CENTERS		
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		7,307
61	6100 EMERGENCY	-104,028	1,082,241
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC		135,928
63.51	6311 RURAL HEALTH CLINIC 2		343,225
63.52	6312 RURAL HEALTH CLINIC 3		262,080
63.53	6313 RURAL HEALTH CLINIC 4		215,173
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES	-452	545,483
68	5950 OTHER REIMBURSABLE COST CENTERS		
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
89	8900 UTILIZATION REVIEW-SNF		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
92	9200 AMBULATORY SURGICAL CENTER (D.P.)		
94	6950 OTHER SPECIAL PURPOSE (SPECIFY)		
95	SUBTOTALS	-201,934	8,669,236
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
97	9700 RESEARCH		
98	9800 PHYSICIANS' PRIVATE OFFICES		45,545
98.01	9801 JAIL MEALS		
98.02	9802 OUTPATIENT MEALS		
98.03	9803 IDLE SPACE		
99	9900 NONPAID WORKERS		
100	7950 OTHER NONREIMBURSABLE COST CENTERS		
101	TOTAL	-201,934	8,714,781

COST CENTERS USED IN COST REPORT

PROVIDER NO: 14-1300
 PERIOD: FROM 9/1/2009 TO 8/31/2010
 PREPARED 2/14/2011
 NOT A CMS WORKSHEET

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
1	OLD CAP REL COSTS-BLDG & FIXT	0100	
2	OLD CAP REL COSTS-MVBLE EQUIP	0200	
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
24	PARAMED ED PRGM	2400	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
31	SUBPROVIDER	3100	
35	NURSING FACILITY	3500	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
47	BLOOD STORING, PROCESSING & TRANS.	4700	
48	INTRAVENOUS THERAPY	4800	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
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	OTHER ANCILLARY SERVICE COST CENTERS	3950	OTHER ANCILLARY SERVICE COST CENTERS
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
63.51	RURAL HEALTH CLINIC 2	6311	RURAL HEALTH CLINIC #####
63.52	RURAL HEALTH CLINIC 3	6312	RURAL HEALTH CLINIC #####
63.53	RURAL HEALTH CLINIC 4	6313	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
68	OTHER REIMBURSABLE COST CENTERS	5950	OTHER REIMBURSABLE COST CENTERS
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
89	UTILIZATION REVIEW-SNF	8900	
90	OTHER CAPITAL RELATED COSTS	9000	
92	AMBULATORY SURGICAL CENTER (D.P.)	9200	
94	OTHER SPECIAL PURPOSE (SPECIFY)	6950	OTHER SPECIAL PURPOSE (SPECIFY)
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	JAIL MEALS	9801	PHYSICIANS' PRIVATE OFFICES
98.02	OUTPATIENT MEALS	9802	PHYSICIANS' PRIVATE OFFICES
98.03	IDLE SPACE	9803	PHYSICIANS' PRIVATE OFFICES
99	NONPAID WORKERS	9900	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:
141300

PERIOD:
FROM 9/ 1/2009
TO 8/31/2010

PREPARED 2/14/2011
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 2	INCREASE		
			LINE NO 3	SALARY 4	OTHER 5
1 RECLASS EQUIPMENT DEPRECIATION	A	NEW CAP REL COSTS-MVBLE EQUIP	4		102,384
2 RECLASS INTEREST EXPENSE	B	ADMINISTRATIVE & GENERAL	6		51,975
3		NEW CAP REL COSTS-MVBLE EQUIP	4		16,896
4 RECLASS SALARIES TO EKG COST CENTER	C	ELECTROCARDIOLOGY	53	12,466	954
5					
6 RECLASSIFY INSURANCE EXPENSES	D	EMPLOYEE BENEFITS	5		125,648
7		OTHER CAPITAL RELATED COSTS	90		636
8		RURAL HEALTH CLINIC	63.50		2,269
9		RURAL HEALTH CLINIC 2	63.51		7,075
10		RURAL HEALTH CLINIC 3	63.52		18,278
11		RURAL HEALTH CLINIC 4	63.53		31,926
12 NURSING ADMIN WAGES & BENEFITS	E	NURSING ADMINISTRATION	14	91,842	6,039
13 RECLASSIFY RHC ADMIN COSTS	F	ADMINISTRATIVE & GENERAL	6		21,183
14		OPERATION OF PLANT	8		22,962
15					
16					
17 ADMIN & HOUSEKEEPING TIME - CLINICS	G	ADMINISTRATIVE & GENERAL	6	150,597	15,114
18		HOUSEKEEPING	10	6,052	1,071
19					
20					
21 LAB TIME	H	LABORATORY	44	6,751	1,215
22					
23					
24		BLOOD STORING, PROCESSING & TRANS.	47	1,880	133
25 RECLASSIFY ER ADMIN TIME	I	ADMINISTRATIVE & GENERAL	6	23,977	15,569
26 RECLASSIFY LEASES TO CAPITAL	J	NEW CAP REL COSTS-MVBLE EQUIP	4		278,465
27					
28					
29					
36 TOTAL RECLASSIFICATIONS				293,565	719,792

(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

EXPLANATION OF RECLASSIFICATION	CODE (1)	DECREASE				A-7 REF 10
		COST CENTER 6	LINE NO 7	SALARY 8	OTHER 9	
1 RECLASS EQUIPMENT DEPRECIATION	A	NEW CAP REL COSTS-BLDG & FIXT	3		102,384	9
2 RECLASS INTEREST EXPENSE	B	INTEREST EXPENSE	88		68,871	
3						
4 RECLASS SALARIES TO EKG COST CENTER	C	RADIOLOGY-DIAGNOSTIC	41	5,976	457	11
5		ADULTS & PEDIATRICS	25	6,490	497	
6 RECLASSIFY INSURANCE EXPENSES	D	ADMINISTRATIVE & GENERAL	6		185,832	
7						
8						
9						
10						
11						
12 NURSING ADMIN WAGES & BENEFITS	E	ADMINISTRATIVE & GENERAL	6	91,842	6,039	
13 RECLASSIFY RHC ADMIN COSTS	F	RURAL HEALTH CLINIC	63.50		11,614	
14		RURAL HEALTH CLINIC 2	63.51		14,243	
15		RURAL HEALTH CLINIC 3	63.52		8,829	
16		RURAL HEALTH CLINIC 4	63.53		9,459	
17 ADMIN & HOUSEKEEPING TIME - CLINICS	G	RURAL HEALTH CLINIC	63.50	24,180	1,990	
18		RURAL HEALTH CLINIC 2	63.51	64,564	3,076	
19		RURAL HEALTH CLINIC 3	63.52	48,540	6,198	
20		RURAL HEALTH CLINIC 4	63.53	19,365	4,921	
21 LAB TIME	H	RURAL HEALTH CLINIC	63.50	827	69	
22		RURAL HEALTH CLINIC 3	63.52	2,828	360	
23		RURAL HEALTH CLINIC 4	63.53	3,096	786	
24		LABORATORY	44	1,880	133	
25 RECLASSIFY ER ADMIN TIME	I	EMERGENCY	61	23,977	15,569	
26 RECLASSIFY LEASES TO CAPITAL	J	OPERATION OF PLANT	8		12,180	10
27		ADULTS & PEDIATRICS	25		21,642	10
28		RADIOLOGY-DIAGNOSTIC	41		188,387	10
29		LABORATORY	44		56,256	10
36 TOTAL RECLASSIFICATIONS				293,565	719,792	

(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:
141300

PERIOD:
FROM 9/ 1/2009
TO 8/31/2010

PREPARED 2/14/2011
WORKSHEET A-6
NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : RECLASS EQUIPMENT DEPRECIATION

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	102,384	NEW CAP REL COSTS-BLDG & FIXT	3	102,384	
TOTAL RECLASSIFICATIONS FOR CODE A			102,384				102,384

RECLASS CODE: B
EXPLANATION : RECLASS INTEREST EXPENSE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	51,975	INTEREST EXPENSE	88	68,871	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	16,896			0	
TOTAL RECLASSIFICATIONS FOR CODE B			68,871				68,871

RECLASS CODE: C
EXPLANATION : RECLASS SALARIES TO EKG COST CENTER

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ELECTROCARDIOLOGY	53	13,420	RADIOLOGY-DIAGNOSTIC	41	6,433	
2.00			0	ADULTS & PEDIATRICS	25	6,987	
TOTAL RECLASSIFICATIONS FOR CODE C			13,420				13,420

RECLASS CODE: D
EXPLANATION : RECLASSIFY INSURANCE EXPENSES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	EMPLOYEE BENEFITS	5	125,648	ADMINISTRATIVE & GENERAL	6	185,832	
2.00	OTHER CAPITAL RELATED COSTS	90	636			0	
3.00	RURAL HEALTH CLINIC	63.50	2,269			0	
4.00	RURAL HEALTH CLINIC 2	63.51	7,075			0	
5.00	RURAL HEALTH CLINIC 3	63.52	18,278			0	
6.00	RURAL HEALTH CLINIC 4	63.53	31,926			0	
TOTAL RECLASSIFICATIONS FOR CODE D			185,832				185,832

RECLASS CODE: E
EXPLANATION : NURSING ADMIN WAGES & BENEFITS

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NURSING ADMINISTRATION	14	97,881	ADMINISTRATIVE & GENERAL	6	97,881	
TOTAL RECLASSIFICATIONS FOR CODE E			97,881				97,881

RECLASS CODE: F
EXPLANATION : RECLASSIFY RHC ADMIN COSTS

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	21,183	RURAL HEALTH CLINIC	63.50	11,614	
2.00	OPERATION OF PLANT	8	22,962	RURAL HEALTH CLINIC 2	63.51	14,243	
3.00			0	RURAL HEALTH CLINIC 3	63.52	8,829	
4.00			0	RURAL HEALTH CLINIC 4	63.53	9,459	
TOTAL RECLASSIFICATIONS FOR CODE F			44,145				44,145

RECLASS CODE: G
EXPLANATION : ADMIN & HOUSEKEEPING TIME - CLINICS

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	165,711	RURAL HEALTH CLINIC	63.50	26,170	
2.00	HOUSEKEEPING	10	7,123	RURAL HEALTH CLINIC 2	63.51	67,640	
3.00			0	RURAL HEALTH CLINIC 3	63.52	54,738	
4.00			0	RURAL HEALTH CLINIC 4	63.53	24,286	
TOTAL RECLASSIFICATIONS FOR CODE G			172,834				172,834

RECLASS CODE: H
EXPLANATION : LAB TIME

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	LABORATORY	44	7,966	RURAL HEALTH CLINIC	63.50	896	

RECLASSIFICATIONS

PROVIDER NO:
141300

PERIOD:
FROM 9/ 1/2009
TO 8/31/2010

PREPARED 2/14/2011
WORKSHEET A-6
NOT A CMS WORKSHEET

RECLASS CODE: H
EXPLANATION : LAB TIME

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
2.00			0	RURAL HEALTH CLINIC 3	63.52	3,188	
3.00			0	RURAL HEALTH CLINIC 4	63.53	3,882	
4.00	BLOOD STORING, PROCESSING & TR	47	2,013	LABORATORY	44	2,013	
TOTAL RECLASSIFICATIONS FOR CODE H			9,979				9,979

RECLASS CODE: I
EXPLANATION : RECLASSIFY ER ADMIN TIME

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	39,546	EMERGENCY	61	39,546	
TOTAL RECLASSIFICATIONS FOR CODE I			39,546				39,546

RECLASS CODE: J
EXPLANATION : RECLASSIFY LEASES TO CAPITAL

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	278,465	OPERATION OF PLANT	8	12,180	
2.00			0	ADULTS & PEDIATRICS	25	21,642	
3.00			0	RADIOLOGY-DIAGNOSTIC	41	188,387	
4.00			0	LABORATORY	44	56,256	
TOTAL RECLASSIFICATIONS FOR CODE J			278,465				278,465

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DI SPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND	388,754				318,240	70,514	
2 LAND IMPROVEMENTS	36,143					36,143	
3 BUILDINGS & FIXTURE	2,413,971	25,580		25,580	8,200	2,431,351	
4 BUILDING IMPROVEMENT							
5 FIXED EQUIPMENT	84,028					84,028	
6 MOVABLE EQUIPMENT	1,518,808	52,910		52,910		1,571,718	
7 SUBTOTAL	4,441,704	78,490		78,490	326,440	4,193,754	
8 RECONCILING ITEMS	400,884	51,830		51,830		452,714	
9 TOTAL	4,040,820	26,660		26,660	326,440	3,741,040	

PART III - RECONCILIATION OF CAPITAL COST CENTERS
 DESCRIPTION

* 1 2 3 4 5	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL 8
		GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	
	OLD CAP REL COSTS-BL							
	OLD CAP REL COSTS-MV							
	NEW CAP REL COSTS-BL	2,622,036	17,680	2,604,356	.696158	20,447		20,447
	NEW CAP REL COSTS-MV	1,571,718	435,034	1,136,684	.303842	8,924		8,924
	TOTAL	4,193,754	452,714	3,741,040	1.000000	29,371		29,371

DESCRIPTION SUMMARY OF OLD AND NEW CAPITAL

* 1 2 3 4 5	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
	OLD CAP REL COSTS-BL							
	OLD CAP REL COSTS-MV							
	NEW CAP REL COSTS-BL	62,018	-5,757		20,447			76,708
	NEW CAP REL COSTS-MV	102,384	278,465	14,992	8,924			404,765
	TOTAL	164,402	272,708	14,992	29,371			481,473

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4
 DESCRIPTION SUMMARY OF OLD AND NEW CAPITAL

* 1 2 3 4 5	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
	OLD CAP REL COSTS-BL							
	OLD CAP REL COSTS-MV							
	NEW CAP REL COSTS-BL	164,402						164,402
	NEW CAP REL COSTS-MV							
	TOTAL	164,402						164,402

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

ADJUSTMENTS TO EXPENSES

DESCR IPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER 3	LINE NO 4	
1 INVST INCOME-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-1,904	NEW CAP REL COSTS-MVBLE E	4	11
5 INVESTMENT INCOME-OTHER	B	-5,859	ADMINISTRATIVE & GENERAL	6	
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE	A	-1,911	ADMINISTRATIVE & GENERAL	6	
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-103,663			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-36,382	DIETARY	11	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS	B	-5,757	NEW CAP REL COSTS-BLDG &	3	10
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-3,662	MEDICAL RECORDS & LIBRARY	17	
21 NURSG SCHOOL(TUITN, FEES, BOOKS, ETC.)					
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP			UTILIZATION REVIEW-SNF	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37 PROPERTY TAXES	A	-12,944	ADMINISTRATIVE & GENERAL	6	
38 IRS PENALTIES	A	-397	ADMINISTRATIVE & GENERAL	6	
39 LOBBYING EXPENSE (IN DUES)	A	-3,161	ADMINISTRATIVE & GENERAL	6	
40 MISCELLANEOUS INCOME OFFSETS	A	-581	ADMINISTRATIVE & GENERAL	6	
41 MISCELLANEOUS INCOME OFFSETS	B	-56	MEDICAL RECORDS & LIBRARY	17	
42 MISCELLANEOUS INCOME OFFSETS	B	-335	RADIOLOGY-DIAGNOSTIC	41	
43 MISCELLANEOUS INCOME OFFSETS	B	-100	LABORATORY	44	
44 MISCELLANEOUS INCOME OFFSETS	B	-65	MEDICAL SUPPLIES CHARGED	55	
45 MISCELLANEOUS INCOME OFFSETS	B	-365	EMERGENCY	61	
46 MISCELLANEOUS INCOME OFFSETS	B	-452	AMBULANCE SERVICES	65	
47 ER PHYSICIANS - BENEFIT COST	A	-6,884	EMPLOYEE BENEFITS	5	
48 ER PHYSICIANS - BILLING COST	A	-28,626	ADMINISTRATIVE & GENERAL	6	
49 ER PHYSICIANS - BILLING COST	A	-2,345	EMPLOYEE BENEFITS	5	
49.01 EMPLOYEE DISCOUNTS	A	13,515	EMPLOYEE BENEFITS	5	
50 TOTAL (SUM OF LINES 1 THRU 49)		-201,934			

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

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

PROVIDER NO: 14-1300
 PERIOD: FROM 9/1/2009 TO 8/31/2010
 PREPARED: 2/14/2011
 WORKSHEET: A-8-2
 GROUP: 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	63 50 RHC MEDICAL DIRECTOR	11,740		11,740				
2	44 PATHOLOGIST	2,500		2,500				
3	61 ER PHYSICIAN/PAS	701,351	103,663	597,688				
5	63 53 RHC MEDICAL DIRECTOR	12,517		12,517				
6	63 51 RHC MEDICAL DIRECTOR	1,600		1,600				
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	729,708	103,663	626,045				

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)							
								4
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK							60
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)							21
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)							
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)							
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)							
7	STANDARD TRAVEL EXPENSE RATE							5.82
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE							
			SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
			1	2	3	4	5	
9	TOTAL HOURS WORKED			117.25				
10	AHSEA (SEE INSTRUCTIONS)			67.13				
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	33.57		33.57				
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)			478				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)							
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)							
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)							

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)							
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)		7,871					
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)							
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	7,871						
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)							
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)							
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	7,871						

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)							
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)							
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)		7,871					

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

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)			705				
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)							
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)			705				
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)			122				
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)			827				
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)			32,088				
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)							
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)			32,088				
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)							

OCCUPATIONAL THERAPY

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 1,433
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 7,871
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 1,433
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 9,304
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 8,468

65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

66	COST OF OUTSIDE SUPPLIER SERVICES -	8,468
	(SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I	
	(SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	
	(SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	8,468
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE WITH LINE 65)	

COST ALLOCATION STATISTICS

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
1	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	NOT ENTERED
2	OLD CAP REL COSTS-MVBLE EQUIP	2	DOLLAR	VALUE	NOT ENTERED
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	23	DOLLAR	VALUE	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	7	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	5	GROSS	SALARIES	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
16	PHARMACY	15	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED
24	PARAMED ED PRGM	22	ASSIGNED	TIME	NOT ENTERED

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	OLD CAP REL C OSTS-BLDG & OSTS-MVBLE E	OLD CAP REL C OSTS-MVBLE E	NEW CAP REL C OSTS-BLDG & OSTS-MVBLE E	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL
	0	1	2	3	4	5	5a.00
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &	76,708			76,708			
005 NEW CAP REL COSTS-MVBLE E	404,765				404,765		
006 EMPLOYEE BENEFITS	552,719					552,719	
008 ADMINISTRATIVE & GENERAL	1,220,769			5,097	33,655	71,798	1,331,319
009 OPERATION OF PLANT	233,900			2,732	2,974	5,886	245,492
010 LAUNDRY & LINEN SERVICE	32,606			2,136	9,883	2,780	47,405
011 HOUSEKEEPING	99,945			509	1,426	6,867	108,747
012 DIETARY	183,163			6,829	3,980	16,256	210,228
014 CAFETERIA				766	2,299		3,065
015 NURSING ADMINISTRATION	138,419			890		4,078	143,387
016 CENTRAL SERVICES & SUPPLY				1,527			1,527
017 PHARMACY				727			727
024 MEDICAL RECORDS & LIBRARY	153,556			1,922	18,925	15,890	190,293
025 PARAMED ED PRGM							
031 INPAT ROUTINE SRVC CNTRS							
035 ADULTS & PEDIATRICS	1,314,034			25,827	50,797	131,302	1,521,960
041 SUBPROVIDER							
044 NURSING FACILITY							
046 ANCILLARY SRVC COST CNTRS							
047 RADIOLOGY-DIAGNOSTIC	527,032			4,432	71,633	38,157	641,254
048 LABORATORY	511,684			1,578	139,980	26,322	679,564
050 WHOLE BLOOD & PACKED RED							
053 BLOOD STORING, PROCESSING	17,418						17,418
055 INTRAVENOUS THERAPY							
056 PHYSICAL THERAPY	164,901			3,855	37,806	15,413	221,975
059 ELECTROCARDIOLOGY	42,803				6,884		49,687
060 MEDICAL SUPPLIES CHARGED	91,159					2,161	93,320
061 30 IMPL. DEV. CHARGED TO PAT							
062 DRUGS CHARGED TO PATIENTS	312,218				108		312,326
063 OTHER ANCILLARY SERVICE C							
065 OUTPAT SERVICE COST CNTRS							
068 CLINIC	7,307					774	8,081
092 EMERGENCY	1,082,241			6,536	12,316	52,398	1,153,491
094 OBSERVATION BEDS (NON-DIS							
095 OTHER OUTPATIENT SERVICE							
096 50 RURAL HEALTH CLINIC	135,928			2,446	2,292	15,189	155,855
097 51 RURAL HEALTH CLINIC 2	343,225			2,848	8,686	43,475	398,234
098 52 RURAL HEALTH CLINIC 3	262,080					30,589	292,669
099 53 RURAL HEALTH CLINIC 4	215,173			4,467		20,026	239,666
096 OTHER REIMBURS COST CNTRS							
097 AMBULANCE SERVICES	545,483			1,584	1,121	48,358	596,546
098 OTHER REIMBURSABLE COST C							
099 SPEC PURPOSE COST CENTERS							
092 AMBULATORY SURGICAL CENTE							
094 OTHER SPECIAL PURPOSE (SP							
095 SUBTOTALS	8,669,236			76,708	404,765	547,719	8,664,236
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP							
098 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC	45,545					5,000	50,545
098 01 JAIL MEALS							
098 02 OUTPATIENT MEALS							
098 03 IDLE SPACE							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	8,714,781			76,708	404,765	552,719	8,714,781

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
	6	8	9	10	11	12	14
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL	1,331,319						
009 OPERATION OF PLANT	44,265	289,757					
010 LAUNDRY & LINEN SERVICE	8,548	8,406	64,359				
011 HOUSEKEEPING	19,608	2,003	6,240	136,598			
012 DIETARY	37,906	26,872	53	1,060	276,119		
014 CAFETERIA	553	3,016			95,543	102,177	
015 NURSING ADMINISTRATION	25,854	3,504				928	173,673
016 CENTRAL SERVICES & SUPPLY	275	6,010					
017 PHARMACY	131	2,861					
024 MEDICAL RECORDS & LIBRARY	34,312	7,563		837		3,615	
025 PARAMED ED PRGM							
031 INPAT ROUTINE SRVC CNTRS							
035 ADULTS & PEDIATRICS	274,426	82,807	44,964	86,381	122,547	29,872	124,669
041 SUBPROVIDER							
044 NURSING FACILITY							
046 ANCILLARY SRVC COST CNTRS							
047 RADIOLOGY-DIAGNOSTIC	115,625	17,439	2,249	4,039		8,681	
048 LABORATORY	122,533	6,210		2,794		5,988	
050 WHOLE BLOOD & PACKED RED							
053 BLOOD STORING, PROCESSING	3,141						
055 INTRAVENOUS THERAPY							
056 PHYSICAL THERAPY	40,025	15,170	2,294	1,097		3,506	
059 ELECTROCARDIOLOGY	8,959						1,269
060 MEDICAL SUPPLIES CHARGED	16,827					492	
061 30 IMPL. DEV. CHARGED TO PAT							
062 DRUGS CHARGED TO PATIENTS	56,316			2,901			
063 OTHER ANCILLARY SERVICE C							
065 OUTPAT SERVICE COST CNTRS							
066 CLINIC	1,457					176	
068 EMERGENCY	207,987	25,719	7,169	10,311		11,920	47,735
092 OBSERVATION BEDS (NON-DIS							
094 OTHER OUTPATIENT SERVICE							
095 50 RURAL HEALTH CLINIC	28,102		58	2,608		3,455	
096 51 RURAL HEALTH CLINIC 2	71,806	11,207		9,951		9,890	
097 52 RURAL HEALTH CLINIC 3	52,771			6,040		6,959	
098 53 RURAL HEALTH CLINIC 4	43,214		3	4,072		4,556	
099 OTHER REIMBURS COST CNTRS							
100 AMBULANCE SERVICES	107,564	6,232	1,329	1,075		11,001	
101 OTHER REIMBURSABLE COST C							
102 SPEC PURPOSE COST CENTERS							
103 092 AMBULATORY SURGICAL CENTE							
094 OTHER SPECIAL PURPOSE (SP							
095 SUBTOTALS	1,322,205	225,019	64,359	133,166	218,090	101,039	173,673
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP							
098 RESEARCH							
099 PHYSICIANS' PRIVATE OFFIC	9,114	45,909		3,432		1,138	
100 01 JAIL MEALS					58,029		
101 02 OUTPATIENT MEALS							
102 03 IDLE SPACE		18,829					
103 099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	1,331,319	289,757	64,359	136,598	276,119	102,177	173,673

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMEDICAL PRGM	ED PR	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	15	16	17	24		25	26	27
001	GENERAL SERVICE COST CNTR							
002	OLD CAP REL COSTS-BLDG &							
003	OLD CAP REL COSTS-MVBLE E							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENERAL							
009	OPERATION OF PLANT							
010	LAUNDRY & LINEN SERVICE							
011	HOUSEKEEPING							
012	DIETARY							
014	CAFETERIA							
015	NURSING ADMINISTRATION							
016	CENTRAL SERVICES & SUPPLY	7,812						
017	PHARMACY		3,719					
024	MEDICAL RECORDS & LIBRARY			236,620				
025	PARAMEDICAL PRGM							
031	INPAT ROUTINE SRVC CNTRS							
035	ADULTS & PEDIATRICS			102,149		2,389,775		2,389,775
041	SUBPROVIDER							
044	NURSING FACILITY							
046	ANCILLARY SRVC COST CNTRS							
047	RADIOLOGY-DIAGNOSTIC			60,697		849,984		849,984
048	LABORATORY					817,089		817,089
050	WHOLE BLOOD & PACKED RED							
053	BLOOD STORING, PROCESSING					20,559		20,559
055	INTRAVENOUS THERAPY							
056	PHYSICAL THERAPY			12,337		296,404		296,404
059	ELECTROCARDIOLOGY			9,869		69,784		69,784
060	MEDICAL SUPPLIES CHARGED	7,812				118,451		118,451
061	30 IMPL. DEV. CHARGED TO PAT							
062	DRUGS CHARGED TO PATIENTS		3,719			375,262		375,262
063	OTHER ANCILLARY SERVICE C							
065	OUTPAT SERVICE COST CNTRS							
066	CLINIC			1,234		10,948		10,948
067	EMERGENCY			50,334		1,514,666		1,514,666
068	OBSERVATION BEDS (NON-DIS							
069	OTHER OUTPATIENT SERVICE							
070	50 RURAL HEALTH CLINIC					190,078		190,078
071	51 RURAL HEALTH CLINIC 2					501,088		501,088
072	52 RURAL HEALTH CLINIC 3					358,439		358,439
073	53 RURAL HEALTH CLINIC 4					291,511		291,511
074	OTHER REIMBURS COST CNTRS							
075	AMBULANCE SERVICES					723,747		723,747
076	OTHER REIMBURSABLE COST C							
077	SPEC PURPOSE COST CENTERS							
078	AMBULATORY SURGICAL CENTE							
079	OTHER SPECIAL PURPOSE (SP							
080	SUBTOTALS	7,812	3,719	236,620		8,527,785		8,527,785
081	NONREIMBURS COST CENTERS							
082	GIFT, FLOWER, COFFEE SHOP							
083	RESEARCH							
084	PHYSICIANS' PRIVATE OFFIC					110,138		110,138
085	01 JAIL MEALS					58,029	-18,435	39,594
086	02 OUTPATIENT MEALS							
087	03 IDLE SPACE					18,829		18,829
088	NONPAID WORKERS							
089	OTHER NONREIMBURSABLE COS							
090	CROSS FOOT ADJUSTMENT							
091	NEGATIVE COST CENTER							
092	TOTAL	7,812	3,719	236,620		8,714,781	-18,435	8,696,346

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-MVBLE E	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS
	0	1	2	3	4	4a	5
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL OPERATION OF PLANT				5,097	33,655	38,752	
009 LAUNDRY & LINEN SERVICE				2,732	2,974	5,706	
010 HOUSEKEEPING				2,136	9,883	12,019	
011 DIETARY				509	1,426	1,935	
012 CAFETERIA				6,829	3,980	10,809	
014 NURSING ADMINISTRATION				766	2,299	3,065	
015 CENTRAL SERVICES & SUPPLY				890		890	
016 PHARMACY				1,527		1,527	
017 MEDICAL RECORDS & LIBRARY				727		727	
024 PARAMED ED PRGM				1,922	18,925	20,847	
025 INPAT ROUTINE SRVC CNTRS							
031 ADULTS & PEDIATRICS				25,827	50,797	76,624	
035 SUBPROVIDER							
041 NURSING FACILITY							
044 ANCI LLARY SRVC COST CNTRS							
046 RADIOLOGY-DIAGNOSTIC LABORATORY				4,432	71,633	76,065	
047 WHOLE BLOOD & PACKED RED BLOOD STORING, PROCESSING				1,578	139,980	141,558	
048 INTRAVENOUS THERAPY							
050 PHYSICAL THERAPY				3,855	37,806	41,661	
053 ELECTROCARDIOLOGY					6,884	6,884	
055 MEDICAL SUPPLIES CHARGED							
056 30 IMPL. DEV. CHARGED TO PAT							
059 DRUGS CHARGED TO PATIENTS					108	108	
060 OTHER ANCI LLARY SERVICE C							
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
062 EMERGENCY				6,536	12,316	18,852	
063 OBSERVATION BEDS (NON-DIS							
063 50 OTHER OUTPATIENT SERVICE							
063 51 RURAL HEALTH CLINIC				2,446	2,292	4,738	
063 52 RURAL HEALTH CLINIC 2				2,848	8,686	11,534	
063 53 RURAL HEALTH CLINIC 3							
063 53 RURAL HEALTH CLINIC 4				4,467		4,467	
065 OTHER REIMBURS COST CNTRS							
068 AMBULANCE SERVICES				1,584	1,121	2,705	
092 OTHER REIMBURSABLE COST C							
094 SPEC PURPOSE COST CENTERS							
095 AMBULATORY SURGICAL CENTE							
095 OTHER SPECIAL PURPOSE (SP							
095 SUBTOTALS				76,708	404,765	481,473	
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
098 01 JAIL MEALS							
098 02 OUTPATIENT MEALS							
098 03 IDLE SPACE							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL				76,708	404,765	481,473	

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
	6	8	9	10	11	12	14
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL	38,752						
009 OPERATION OF PLANT	1,288	6,994					
010 LAUNDRY & LINEN SERVICE	249	203	12,471				
011 HOUSEKEEPING	571	48	1,209	3,763			
012 DIETARY	1,103	649	10	29	12,600		
014 CAFETERIA	16	73			4,360	7,514	
015 NURSING ADMINISTRATION	752	85				68	1,795
016 CENTRAL SERVICES & SUPPLY	8	145					
017 PHARMACY	4	69					
024 MEDICAL RECORDS & LIBRARY	999	183		23		266	
025 PARAMED ED PRGM							
031 INPAT ROUTINE SRVC CNTRS							
035 ADULTS & PEDIATRICS	7,991	1,998	8,712	2,380	5,592	2,197	1,289
041 SUBPROVIDER							
044 NURSING FACILITY							
046 ANCILLARY SRVC COST CNTRS							
047 RADIOLOGY-DIAGNOSTIC	3,365	421	436	111		638	
050 LABORATORY	3,566	150		77		440	
053 WHOLE BLOOD & PACKED RED							
055 BLOOD STORING, PROCESSING	91						
056 INTRAVENOUS THERAPY							
059 PHYSICAL THERAPY	1,165	366	445	30		258	
060 ELECTROCARDIOLOGY	261						13
061 MEDICAL SUPPLIES CHARGED	490					36	
062 30 IMPL. DEV. CHARGED TO PAT							
063 DRUGS CHARGED TO PATIENTS	1,639			80			
065 OTHER ANCILLARY SERVICE C							
068 OUTPAT SERVICE COST CNTRS							
092 CLINIC	42					13	
094 EMERGENCY	6,054	621	1,389	284		877	493
095 OBSERVATION BEDS (NON-DIS							
096 OTHER OUTPATIENT SERVICE							
097 50 RURAL HEALTH CLINIC	818		11	72		254	
098 51 RURAL HEALTH CLINIC 2	2,090	271		274		727	
099 52 RURAL HEALTH CLINIC 3	1,536			166		512	
100 53 RURAL HEALTH CLINIC 4	1,258		1	112		335	
101 OTHER REIMBURS COST CNTRS							
102 AMBULANCE SERVICES	3,131	150	258	30		809	
103 OTHER REIMBURSABLE COST C							
104 SPEC PURPOSE COST CENTERS							
105 AMBULATORY SURGICAL CENTE							
106 OTHER SPECIAL PURPOSE (SP							
107 SUBTOTALS	38,487	5,432	12,471	3,668	9,952	7,430	1,795
108 NONREIMBURS COST CENTERS							
109 GIFT, FLOWER, COFFEE SHOP							
110 RESEARCH							
111 PHYSICIANS' PRIVATE OFFIC	265	1,108		95		84	
112 01 JAIL MEALS					2,648		
113 02 OUTPATIENT MEALS							
114 03 IDLE SPACE		454					
115 NONPAID WORKERS							
116 OTHER NONREIMBURSABLE COS							
117 CROSS FOOT ADJUSTMENTS							
118 NEGATIVE COST CENTER							
119 TOTAL	38,752	6,994	12,471	3,763	12,600	7,514	1,795

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	PARAMEDICAL PRGM 24	SUBTOTAL 25	POST STEPDOWN ADJUSTMENT 26	TOTAL 27
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
014 CAFETERIA							
015 NURSING ADMINISTRATION	1,680						
016 CENTRAL SERVICES & SUPPLY		800					
017 PHARMACY			22,318				
024 MEDICAL RECORDS & LIBRARY							
025 PARAMEDICAL PRGM							
031 INPAT ROUTINE SRVC CNTRS			9,634		116,417		116,417
035 ADULTS & PEDIATRICS							
041 SUBPROVIDER							
044 NURSING FACILITY							
046 ANCILLARY SRVC COST CNTRS			5,725		86,761		86,761
047 RADIOLOGY-DIAGNOSTIC					145,791		145,791
048 LABORATORY							
050 WHOLE BLOOD & PACKED RED							
053 BLOOD STORING, PROCESSING					91		91
055 INTRAVENOUS THERAPY							
056 PHYSICAL THERAPY			1,164		45,089		45,089
059 ELECTROCARDIOLOGY			931		8,089		8,089
060 MEDICAL SUPPLIES CHARGED	1,680				2,206		2,206
061 30 IMPL. DEV. CHARGED TO PAT							
062 DRUGS CHARGED TO PATIENTS		800			2,627		2,627
063 OTHER ANCILLARY SERVICE C							
065 OUTPAT SERVICE COST CNTRS							
066 CLINIC							
067 EMERGENCY			116		171		171
068 OBSERVATION BEDS (NON-DIS			4,748		33,318		33,318
069 OTHER OUTPATIENT SERVICE							
070 50 RURAL HEALTH CLINIC					5,893		5,893
071 51 RURAL HEALTH CLINIC 2					14,896		14,896
072 52 RURAL HEALTH CLINIC 3					2,214		2,214
073 53 RURAL HEALTH CLINIC 4					6,173		6,173
074 OTHER REIMBURS COST CNTRS							
075 AMBULANCE SERVICES					7,083		7,083
076 OTHER REIMBURSABLE COST C							
077 SPEC PURPOSE COST CENTERS							
078 AMBULATORY SURGICAL CENTE							
079 OTHER SPECIAL PURPOSE (SP							
080 SUBTOTALS	1,680	800	22,318		476,819		476,819
081 NONREIMBURS COST CENTERS							
082 GIFT, FLOWER, COFFEE SHOP							
083 RESEARCH							
084 PHYSICIANS' PRIVATE OFFIC					1,552		1,552
085 01 JAIL MEALS					2,648		2,648
086 02 OUTPATIENT MEALS							
087 03 IDLE SPACE					454		454
088 NONPAID WORKERS							
089 OTHER NONREIMBURSABLE COS							
090 CROSS FOOT ADJUSTMENTS							
091 NEGATIVE COST CENTER							
092 TOTAL	1,680	800	22,318		481,473		481,473

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	(HOURS OF SERVICE)	(MEALS SERVED)	S(GROSS)ALARIES	S(DIRECT)SING HRS	NR)
	6	8	9	10	11	12	14	
001	GENERAL SERVICE COST							
002	OLD CAP REL COSTS-BLD							
003	OLD CAP REL COSTS-MVB							
004	NEW CAP REL COSTS-BLD							
005	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE	7,383,462						
008	OPERATION OF PLANT	245,492	39,195					
009	LAUNDRY & LINEN SERVI	47,405	1,137	67,407				
010	HOUSEKEEPING	108,747	271	6,535	89,557			
011	DIETARY	210,228	3,635	56	695	25,062		
012	CAFETERIA	3,065	408			8,672	3,958,497	
014	NURSING ADMINISTRATION	143,387	474				35,944	40,381
015	CENTRAL SERVICES & SU	1,527	813					
016	PHARMACY	727	387					
017	MEDICAL RECORDS & LIB	190,293	1,023		549	140,053		
024	PARAMED ED PRGM							
025	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	1,521,960	11,201	47,092	56,633	11,123	1,157,240	28,987
031	SUBPROVIDER							
035	NURSING FACILITY							
041	ANCILLARY SRVC COST C							
041	RADIOLOGY-DIAGNOSTIC	641,254	2,359	2,356	2,648		336,300	
044	LABORATORY	679,564	840		1,832		231,997	
046	WHOLE BLOOD & PACKED							
047	BLOOD STORING PROCES	17,418						
048	INTRAVENOUS THERAPY							
050	PHYSICAL THERAPY	221,975	2,052	2,403	719		135,845	
053	ELECTROCARDIOLOGY	49,687						295
055	MEDICAL SUPPLIES CHAR	93,320					19,049	
055	30 IMPL. DEV. CHARGED TO							
056	DRUGS CHARGED TO PATI	312,326			1,902			
059	OTHER ANCILLARY SERVI							
060	OUTPAT SERVICE COST C							
060	CLINIC	8,081				6,820		
061	EMERGENCY	1,153,491	3,479	7,509	6,760	461,820		11,099
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063	50 RURAL HEALTH CLINIC	155,855		61	1,710		133,870	
063	51 RURAL HEALTH CLINIC 2	398,234	1,516		6,524		383,173	
063	52 RURAL HEALTH CLINIC 3	292,669			3,960		269,603	
063	53 RURAL HEALTH CLINIC 4	239,666		3	2,670		176,500	
065	OTHER REIMBURS COST C							
065	AMBULANCE SERVICES	596,546	843	1,392	705		426,213	
068	OTHER REIMBURSABLE CO							
092	SPEC PURPOSE COST CEN							
094	AMBULATORY SURGICAL C							
094	OTHER SPECIAL PURPOSE							
095	SUBTOTALS	7,332,917	30,438	67,407	87,307	19,795	3,914,427	40,381
096	NONREIMBURS COST CENT							
097	GIFT, FLOWER, COFFEE							
097	RESEARCH							
098	PHYSICIANS' PRIVATE O	50,545	6,210		2,250		44,070	
098	01 JAIL MEALS					5,267		
098	02 OUTPATIENT MEALS							
098	03 IDLE SPACE		2,547					
099	NONPAID WORKERS							
100	OTHER NONREIMBURSABLE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	1,331,319	289,757	64,359	136,598	276,119	102,177	173,673
104	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER		7.392703		1.525263		.025812	
105	(WRKSHT B, PT I)	.180311		.954782		11.017437		4.300859
105	COST TO BE ALLOCATED							
106	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
106	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	38,752	6,994	12,471	3,763	12,600	7,514	1,795
107	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER		.178441		.042018		.001898	
108	(WRKSHT B, PT III)	.005248		.185010		.502753		.044452

POST STEP DOWN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 2/14/2011
 I 14-1300 I FROM 9/ 1/2009 I
 I I TO 8/31/2010 I WORKSHEET B-2

DESCRIPTION	WORKSHEET		AMOUNT
	PART	LINE NO.	
1	2	3	4
1 ADJ FOR EPO COSTS IN RENAL DIA	1	57	
2 ADJ FOR EPO COSTS IN HOME PROG	1	64	
3 ADJ FOR ARANESP IN RENAL DIALY	1	57	
4 ADJ FOR ARANESP IN HOME PROGRA	1	64	
9 JAIL MEALS	1	98 1	-18,435

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DI ALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,389,775		2,389,775		
31	SUBPROVIDER					
35	NURSING FACILITY					
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC	849,984		849,984		
44	LABORATORY	817,089		817,089		
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING	20,559		20,559		
48	INTRAVENOUS THERAPY					
50	PHYSICAL THERAPY	296,404		296,404		
53	ELECTROCARDIOLOGY	69,784		69,784		
55	MEDICAL SUPPLIES CHARGED	118,451		118,451		
55	30 IMPL. DEV. CHARGED TO PAT					
56	DRUGS CHARGED TO PATIENTS	375,262		375,262		
59	OTHER ANCILLARY SERVICE C					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	10,948		10,948		
61	EMERGENCY	1,514,666		1,514,666		
62	OBSERVATION BEDS (NON-DIS	317,383		317,383		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	190,078		190,078		
63	51 RURAL HEALTH CLINIC 2	501,088		501,088		
63	52 RURAL HEALTH CLINIC 3	358,439		358,439		
63	53 RURAL HEALTH CLINIC 4	291,511		291,511		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	723,747		723,747		
68	OTHER REIMBURSABLE COST C					
101	SUBTOTAL	8,845,168		8,845,168		
102	LESS OBSERVATION BEDS	317,383		317,383		
103	TOTAL	8,527,785		8,527,785		

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
41	ANCILLARY SRVC COST CNTRS						
	RADIOLOGY-DIAGNOSTIC	849,984	86,761	763,223			849,984
44	LABORATORY	817,089	145,791	671,298			817,089
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING	20,559	91	20,468			20,559
48	INTRAVENOUS THERAPY						
50	PHYSICAL THERAPY	296,404	45,089	251,315			296,404
53	ELECTROCARDIOLOGY	69,784	8,089	61,695			69,784
55	MEDICAL SUPPLIES CHARGED	118,451	2,206	116,245			118,451
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS	375,262	2,627	372,635			375,262
59	OTHER ANCILLARY SERVICE C						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	10,948	171	10,777			10,948
61	EMERGENCY	1,514,666	33,318	1,481,348			1,514,666
62	OBSERVATION BEDS (NON-DIS	317,383		317,383			317,383
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	190,078	5,893	184,185			190,078
63	51 RURAL HEALTH CLINIC 2	501,088	14,896	486,192			501,088
63	52 RURAL HEALTH CLINIC 3	358,439	2,214	356,225			358,439
63	53 RURAL HEALTH CLINIC 4	291,511	6,173	285,338			291,511
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	723,747	7,083	716,664			723,747
68	OTHER REIMBURSABLE COST C						
101	SUBTOTAL	6,455,393	360,402	6,094,991			6,455,393
102	LESS OBSERVATION BEDS	317,383		317,383			317,383
103	TOTAL	6,138,010	360,402	5,777,608			6,138,010

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
41	ANCILLARY SRVC COST CNTRS			
	RADIOLOGY-DIAGNOSTIC	3,021,763	.281287	.281287
44	LABORATORY	2,744,763	.297690	.297690
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING	85,666	.239990	.239990
48	INTRAVENOUS THERAPY			
50	PHYSICAL THERAPY	607,156	.488184	.488184
53	ELECTROCARDIOLOGY	592,450	.117789	.117789
55	MEDICAL SUPPLIES CHARGED	483,588	.244942	.244942
55	30 IMPL. DEV. CHARGED TO PAT			
56	DRUGS CHARGED TO PATIENTS	1,168,350	.321190	.321190
59	OTHER ANCILLARY SERVICE C			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	37,421	.292563	.292563
61	EMERGENCY	1,637,727	.924859	.924859
62	OBSERVATION BEDS (NON-DIS	672,174	.472174	.472174
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	126,886	1.498022	1.498022
63	51 RURAL HEALTH CLINIC 2	442,387	1.132692	1.132692
63	52 RURAL HEALTH CLINIC 3	258,899	1.384474	1.384474
63	53 RURAL HEALTH CLINIC 4	149,906	1.944625	1.944625
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	999,911	.723811	.723811
68	OTHER REIMBURSABLE COST C			
101	SUBTOTAL	13,029,047		
102	LESS OBSERVATION BEDS	672,174		
103	TOTAL	12,356,873		

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
41	ANCILLARY SRVC COST CNTRS						
	RADIOLOGY-DIAGNOSTIC	849,984	86,761	763,223			849,984
44	LABORATORY	817,089	145,791	671,298			817,089
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING	20,559	91	20,468			20,559
48	INTRAVENOUS THERAPY						
50	PHYSICAL THERAPY	296,404	45,089	251,315			296,404
53	ELECTROCARDIOLOGY	69,784	8,089	61,695			69,784
55	MEDICAL SUPPLIES CHARGED	118,451	2,206	116,245			118,451
55	30 IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS	375,262	2,627	372,635			375,262
59	OTHER ANCILLARY SERVICE C						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	10,948	171	10,777			10,948
61	EMERGENCY	1,514,666	33,318	1,481,348			1,514,666
62	OBSERVATION BEDS (NON-DIS	317,383		317,383			317,383
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	190,078	5,893	184,185			190,078
63	51 RURAL HEALTH CLINIC 2	501,088	14,896	486,192			501,088
63	52 RURAL HEALTH CLINIC 3	358,439	2,214	356,225			358,439
63	53 RURAL HEALTH CLINIC 4	291,511	6,173	285,338			291,511
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	723,747	7,083	716,664			723,747
68	OTHER REIMBURSABLE COST C						
101	SUBTOTAL	6,455,393	360,402	6,094,991			6,455,393
102	LESS OBSERVATION BEDS	317,383		317,383			317,383
103	TOTAL	6,138,010	360,402	5,777,608			6,138,010

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
41	ANCILLARY SRVC COST CNTRS			
	RADIOLOGY-DIAGNOSTIC	3,021,763	.281287	.281287
44	LABORATORY	2,744,763	.297690	.297690
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING	85,666	.239990	.239990
48	INTRAVENOUS THERAPY			
50	PHYSICAL THERAPY	607,156	.488184	.488184
53	ELECTROCARDIOLOGY	592,450	.117789	.117789
55	MEDICAL SUPPLIES CHARGED	483,588	.244942	.244942
55	30 IMPL. DEV. CHARGED TO PAT			
56	DRUGS CHARGED TO PATIENTS	1,168,350	.321190	.321190
59	OTHER ANCILLARY SERVICE C			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	37,421	.292563	.292563
61	EMERGENCY	1,637,727	.924859	.924859
62	OBSERVATION BEDS (NON-DIS	672,174	.472174	.472174
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	126,886	1.498022	1.498022
63	51 RURAL HEALTH CLINIC 2	442,387	1.132692	1.132692
63	52 RURAL HEALTH CLINIC 3	258,899	1.384474	1.384474
63	53 RURAL HEALTH CLINIC 4	149,906	1.944625	1.944625
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	999,911	.723811	.723811
68	OTHER REIMBURSABLE COST C			
101	SUBTOTAL	13,029,047		
102	LESS OBSERVATION BEDS	672,174		
103	TOTAL	12,356,873		

TITLE XVIII, PART B HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
41 RADIOLOGY-DIAGNOSTIC	.281287		.281287		
44 LABORATORY	.297690		.297690		
46 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47 BLOOD STORING, PROCESSING & TRANS.	.239990		.239990		
48 INTRAVENOUS THERAPY					
50 PHYSICAL THERAPY	.488184		.488184		
53 ELECTROCARDIOLOGY	.117789		.117789		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.244942		.244942		
55 30 IMPL. DEV. CHARGED TO PATIENT					
56 DRUGS CHARGED TO PATIENTS	.321190		.321190		
59 OTHER ANCILLARY SERVICE COST CENTERS					
60 OUTPAT SERVICE COST CNTRS					
60 CLINIC	.292563		.292563		
61 EMERGENCY	.924859		.924859		
62 OBSERVATION BEDS (NON-DISTINCT PART)	.472174		.472174		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
63 53 RURAL HEALTH CLINIC 4					
65 OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.723811		.723811		
68 OTHER REIMBURSABLE COST CENTERS					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	HOSPITAL		Hospital I/P Part B Costs
	All	Other	
	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
41 RADIOLOGY-DIAGNOSTIC		266,562	
44 LABORATORY		355,394	
46 WHOLE BLOOD & PACKED RED BLOOD CELLS			
47 BLOOD STORING, PROCESSING & TRANS.		8,515	
48 INTRAVENOUS THERAPY			
50 PHYSICAL THERAPY		78,063	
53 ELECTROCARDIOLOGY		32,964	
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		34,365	
30 56 IMPL. DEV. CHARGED TO PATIENT			
56 DRUGS CHARGED TO PATIENTS		90,633	
59 OTHER ANCILLARY SERVICE COST CENTERS			
60 OUTPAT SERVICE COST CNTRS			
60 CLINIC			
61 EMERGENCY		714,921	
62 OBSERVATION BEDS (NON-DISTINCT PART)		89,996	
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
63 51 RURAL HEALTH CLINIC 2			
63 52 RURAL HEALTH CLINIC 3			
63 53 RURAL HEALTH CLINIC 4			
65 OTHER REIMBURS COST CNTRS			
65 AMBULANCE SERVICES			
68 OTHER REIMBURSABLE COST CENTERS			
101 SUBTOTAL		1,671,413	
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES		1,671,413	

(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

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1 .321190
2	PROGRAM VACCINE CHARGES	260
3	PROGRAM COSTS	84

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,702
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,190
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,190
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	348
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)	610
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	603
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)	951
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	652
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	321
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)	581
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	117.51
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	118.46
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,389,775
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	70,859
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	112,655
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,167,495
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,222,280

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	837,302
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	837,302
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.459784
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	703.62
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	1,222,280

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 1,027.12
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 669,682
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 669,682

	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					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					205,980

875,662

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) 329,706
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST
REPORTING PERIOD (SEE INSTRUCTIONS) 596,757
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 926,463
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	309
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,027.13
85	OBSERVATION BED COST	317,383

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

WKST A	COST CENTER DESCRIPTION	RATIO COST TO CHARGES	INPATIENT CHARGES	INPATIENT COST
LINE NO.		1	2	3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		629,773	
31	SUBPROVIDER ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC	.281287	137,166	38,583
44	LABORATORY	.297690	165,282	49,203
46	WHOLE BLOOD & PACKED RED BLOOD CELLS			
47	BLOOD STORING, PROCESSING & TRANS.	.239990	11,193	2,686
48	INTRAVENOUS THERAPY			
50	PHYSICAL THERAPY	.488184	5,106	2,493
53	ELECTROCARDIOLOGY	.117789	19,411	2,286
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.244942	153,801	37,672
55	30 IMPL. DEV. CHARGED TO PATIENT			
56	DRUGS CHARGED TO PATIENTS	.321190	227,456	73,057
59	OTHER ANCILLARY SERVICE COST CENTERS OUTPAT SERVICE COST CNTRS			
60	CLINIC	.292563		
61	EMERGENCY	.924859		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.472174		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
63	51 RURAL HEALTH CLINIC 2			
63	52 RURAL HEALTH CLINIC 3			
63	53 RURAL HEALTH CLINIC 4			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
68	OTHER REIMBURSABLE COST CENTERS			
101	TOTAL		719,415	205,980
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		719,415	

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS			
31	ADULTS & PEDIATRICS			
	SUBPROVIDER			
41	ANCILLARY SRVC COST CNTRS			
44	RADIOLOGY-DIAGNOSTIC	.281287	40,330	11,344
46	LABORATORY	.297690	68,627	20,430
47	WHOLE BLOOD & PACKED RED BLOOD CELLS			
48	BLOOD STORING, PROCESSING & TRANS.	.239990	5,936	1,425
50	INTRAVENOUS THERAPY			
53	PHYSICAL THERAPY	.488184	79,176	38,652
55	ELECTROCARDIOLOGY	.117789	2,233	263
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.244942	148,597	36,398
55	30 IMPL. DEV. CHARGED TO PATIENT			
56	DRUGS CHARGED TO PATIENTS	.321190	189,769	60,952
59	OTHER ANCILLARY SERVICE COST CENTERS			
60	OUTPAT SERVICE COST CNTRS			
61	CLINIC	.292563		
62	EMERGENCY	.924859		
63	OBSERVATION BEDS (NON-DISTINCT PART)	.472174		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
63	51 RURAL HEALTH CLINIC 2			
63	52 RURAL HEALTH CLINIC 3			
63	53 RURAL HEALTH CLINIC 4			
65	OTHER REIMBURS COST CNTRS			
68	AMBULANCE SERVICES			
101	OTHER REIMBURSABLE COST CENTERS			
101	TOTAL		534,668	169,464
102	LESS PBP CLINIC LABORATORY SERVICES -			
103	PROGRAM ONLY CHARGES			
	NET CHARGES		534,668	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	1,671,497
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	1,671,497

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)	1,688,212
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	CAH DEDUCTIBLES	26,350
18.01	CAH ACTUAL BILLED COINSURANCE	558,896
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	1,102,966
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	1,102,966
24	PRIMARY PAYER PAYMENTS	1,549
25	SUBTOTAL	1,101,417

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	132,815
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	132,815
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	100,027
28	SUBTOTAL	1,234,232
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	1,234,232
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	1,533,766
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-299,534
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2	

TO BE COMPLETED BY CONTRACTOR

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

TITLE XVII HOSPITAL

DESCRIPTION	INPATIENT-PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		741,171		1,349,759
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	3/ 5/2010	50,135	3/ 5/2010	159,009
ADJUSTMENTS TO PROVIDER .02	8/27/2010	11,996	8/27/2010	24,998
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
ADJUSTMENTS TO PROGRAM .59				
SUBTOTAL		62,131		184,007
4 TOTAL INTERIM PAYMENTS		803,302		1,533,766
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		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		64,181		299,534
7 TOTAL MEDICARE PROGRAM LIABILITY		739,121		1,234,232

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

TITLE XVII I SWING BED SNF

DESCRIPTION	INPATIENT-PART A		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, 124, 220		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	3/ 5/2010	73, 458		
ADJUSTMENTS TO PROVIDER .02	8/27/2010	15, 444		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
ADJUSTMENTS TO PROGRAM .59				
SUBTOTAL		88, 902		NONE
4 TOTAL INTERIM PAYMENTS		1, 213, 122		
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	NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02		130, 657		
7 TOTAL MEDICARE PROGRAM LIABILITY		1, 082, 465		

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

TITLE 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)	935,728	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	171,159	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	902	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,106,887	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,106,887	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,106,887	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	24,422	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,082,465	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,082,465	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,213,122	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-130,657	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2.		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	875,662
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	875,662
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST FOR CAH (SEE INSTRUCTIONS)	884,419
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCI LLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DI RECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	884,419
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	178,527
21	EXCESS REASONABLE COST	
22	SUBTOTAL	705,892
23	COI NSURANCE	
24	SUBTOTAL	705,892
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS))	33,229
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	33,229
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	26,711
26	SUBTOTAL	739,121
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTI LIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DI SPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	739,121
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	803,302
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-64,181
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTI ON 115.2.	

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
ASSETS				
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	271,627			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	2,773,255			
5 OTHER RECEIVABLES				
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,338,606			
7 INVENTORY	29,629			
8 PREPAID EXPENSES	113,847			
9 OTHER CURRENT ASSETS	350,000			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	2,199,752			
FIXED ASSETS				
12 LAND	70,514			
12.01 LAND IMPROVEMENTS	36,143			
13.01 LESS ACCUMULATED DEPRECIATION	-36,143			
14 BUILDINGS	2,431,351			
14.01 LESS ACCUMULATED DEPRECIATION	-2,157,442			
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT	84,028			
16.01 LESS ACCUMULATED DEPRECIATION	-80,593			
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT	1,571,718			
18.01 LESS ACCUMULATED DEPRECIATION	-1,426,724			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	492,852			
OTHER ASSETS				
22 INVESTMENTS	29,297			
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	83,259			
26 TOTAL OTHER ASSETS	112,556			
27 TOTAL ASSETS	2,805,160			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	950,152			
29 SALARIES, WAGES & FEES PAYABLE	515,720			
30 PAYROLL TAXES PAYABLE	68,767			
31 NOTES AND LOANS PAYABLE (SHORT TERM)	535,382			
32 DEFERRED INCOME	22,044			
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES				
36 TOTAL CURRENT LIABILITIES	2,092,065			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	702,534			
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	702,534			
43 TOTAL LIABILITIES	2,794,599			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	10,561			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	10,561			
52 TOTAL LIABILITIES AND FUND BALANCES	2,805,160			

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING		-1,625,270		
2 OF PERIOD				
3 NET INCOME (LOSS)		1,635,831		
4 TOTAL		10,561		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6 ADDITIONS (CREDIT ADJUSTM				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		10,561		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF		10,561		
PERIOD PER BALANCE SHEET				

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

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	837,302		837,302
2 00 SUBPROVIDER			
4 00 SWING BED - SNF	422,227		422,227
5 00 SWING BED - NF	199,955		199,955
7 00 NURSING FACILITY			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	1,459,484		1,459,484
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	1,459,484		1,459,484
17 00 ANCILLARY SERVICES	1,674,485	7,481,942	9,156,427
18 00 OUTPATIENT SERVICES		2,789,885	2,789,885
18 50 RURAL HEALTH CLINIC		126,886	126,886
18 51 RURAL HEALTH CLINIC 2		479,808	479,808
18 52 RURAL HEALTH CLINIC 3		258,899	258,899
18 53 RURAL HEALTH CLINIC 4		149,906	149,906
20 00 AMBULANCE SERVICES		999,911	999,911
22 00 AMBULATORY SURGICAL CENTER (D. P.)			
24 00			
25 00 TOTAL PATIENT REVENUES	3,133,969	12,287,237	15,421,206

PART II - OPERATING EXPENSES

26 00 OPERATING EXPENSES		8,916,715	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		8,916,715	

DESCRIPTION

1	TOTAL PATIENT REVENUES	15,421,206
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	4,742,352
3	NET PATIENT REVENUES	10,678,854
4	LESS: TOTAL OPERATING EXPENSES	8,916,715
5	NET INCOME FROM SERVICE TO PATIENTS	1,762,139
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	138,301
7	INCOME FROM INVESTMENTS	7,763
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	54,796
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	3,662
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	5,757
23	GOVERNMENTAL APPROPRIATIONS	319,024
24	MISCELLANEOUS INCOME	13,989
24.01	GAIN FROM SALE OF FARM LAND	594,710
24.02	FUNDRAISING, NET	8,455
24.03	WELLNESS CENTER	5,687
24.04	HEALTH FAIR	16,149
24.05	UNREALIZED INVESTMENT GAINS	2,061
25	TOTAL OTHER INCOME	1,170,354
26	TOTAL	2,932,493
	OTHER EXPENSES	
27	FARM EXPENSES	2,336
28	BAD DEBT EXPENSE	1,294,326
29		
30	TOTAL OTHER EXPENSES	1,296,662
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,635,831

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	5,720	471	6,191
2	PHYSICIAN ASSISTANT			
3	NURSE PRACTITIONER	76,885	6,327	83,212
4	VISITING NURSE			
5	OTHER NURSE	4,922	405	5,327
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS	21,335	1,756	23,091
10	SUBTOTAL (SUM OF LINES 1-9)	108,862	8,959	117,821
COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		11,740	11,740
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)		11,740	11,740
OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		3,494	3,494
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS		2,873	2,873
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)		6,367	6,367
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	108,862	27,066	135,928
COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
FACILITY OVERHEAD				
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS			
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)			
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	108,862	27,066	135,928

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS			
1 PHYSICIAN	6,191		6,191
2 PHYSICIAN ASSISTANT			
3 NURSE PRACTITIONER	83,212		83,212
4 VISITING NURSE			
5 OTHER NURSE	5,327		5,327
6 CLINICAL PSYCHOLOGIST			
7 CLINICAL SOCIAL WORKER			
8 LABORATORY TECHNICIAN			
9 OTHER FACILITY HEALTH CARE STAFF COSTS	23,091		23,091
10 SUBTOTAL (SUM OF LINES 1-9)	117,821		117,821
COSTS UNDER AGREEMENT			
11 PHYSICIAN SERVICES UNDER AGREEMENT			
12 PHYSICIAN SUPERVISION UNDER AGREEMENT	11,740		11,740
13 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)	11,740		11,740
OTHER HEALTH CARE COSTS			
15 MEDICAL SUPPLIES	3,494		3,494
16 TRANSPORTATION (HEALTH CARE STAFF)			
17 DEPRECIATION-MEDICAL EQUIPMENT			
18 PROFESSIONAL LIABILITY INSURANCE			
19 OTHER HEALTH CARE COSTS	2,873		2,873
20 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	6,367		6,367
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	135,928		135,928
COSTS OTHER THAN RHC/FQHC SERVICES			
23 PHARMACY			
24 DENTAL			
25 OPTOMETRY			
26 ALL OTHER NONREIMBURSABLE COSTS			
27 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
FACILITY OVERHEAD			
29 FACILITY COSTS			
30 ADMINISTRATIVE COSTS			
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)			
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	135,928		135,928

RHC 2

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2				
3	147,597	7,029	154,626	
4	74,984	3,571	78,555	
5				
6	68,838	3,278	72,116	
7				
8				
9	27,190	1,295	28,485	
10	318,609	15,173	333,782	
COSTS UNDER AGREEMENT				
11				
12		1,600	1,600	
13				
14		1,600	1,600	
OTHER HEALTH CARE COSTS				
15				
16		7,129	7,129	
17				
18				
19		714	714	
20				
21		7,843	7,843	
22	318,609	24,616	343,225	
COSTS OTHER THAN RHC/FQHC SERVICES				
23				
24				
25				
26				
27				
28				
FACILITY OVERHEAD				
29				
30				
31				
32	318,609	24,616	343,225	

RHC 2

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN		
2	PHYSICIAN ASSISTANT	154,626	154,626
3	NURSE PRACTITIONER	78,555	78,555
4	VISITING NURSE		
5	OTHER NURSE	72,116	72,116
6	CLINICAL PSYCHOLOGIST		
7	CLINICAL SOCIAL WORKER		
8	LABORATORY TECHNICIAN		
9	OTHER FACILITY HEALTH CARE STAFF COSTS	28,485	28,485
10	SUBTOTAL (SUM OF LINES 1-9)	333,782	333,782
COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT		
12	PHYSICIAN SUPERVISION UNDER AGREEMENT	1,600	1,600
13	OTHER COSTS UNDER AGREEMENT		
14	SUBTOTAL (SUM OF LINES 11-13)	1,600	1,600
OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	7,129	7,129
16	TRANSPORTATION (HEALTH CARE STAFF)		
17	DEPRECIATION-MEDICAL EQUIPMENT		
18	PROFESSIONAL LIABILITY INSURANCE		
19	OTHER HEALTH CARE COSTS	714	714
20	ALLOWABLE GME COSTS		
21	SUBTOTAL (SUM OF LINES 15-20)	7,843	7,843
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	343,225	343,225
COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY		
24	DENTAL		
25	OPTOMETRY		
26	ALL OTHER NONREIMBURSABLE COSTS		
27	NONALLOWABLE GME COSTS		
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		
FACILITY OVERHEAD			
29	FACILITY COSTS		
30	ADMINISTRATIVE COSTS		
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	343,225	343,225

RHC 3

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS			
1 PHYSICIAN	199,835		199,835
2 PHYSICIAN ASSISTANT	7,176		7,176
3 NURSE PRACTITIONER			
4 VISITING NURSE			
5 OTHER NURSE	38,050		38,050
6 CLINICAL PSYCHOLOGIST			
7 CLINICAL SOCIAL WORKER			
8 LABORATORY TECHNICIAN			
9 OTHER FACILITY HEALTH CARE STAFF COSTS	1,036		1,036
10 SUBTOTAL (SUM OF LINES 1-9)	246,097		246,097
COSTS UNDER AGREEMENT			
11 PHYSICIAN SERVICES UNDER AGREEMENT			
12 PHYSICIAN SUPERVISION UNDER AGREEMENT			
13 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
OTHER HEALTH CARE COSTS			
15 MEDICAL SUPPLIES	6,654		6,654
16 TRANSPORTATION (HEALTH CARE STAFF)			
17 DEPRECIATION-MEDICAL EQUIPMENT			
18 PROFESSIONAL LIABILITY INSURANCE			
19 OTHER HEALTH CARE COSTS	5,729		5,729
20 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	12,383		12,383
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	258,480		258,480
COSTS OTHER THAN RHC/FQHC SERVICES			
23 PHARMACY			
24 DENTAL			
25 OPTOMETRY			
26 ALL OTHER NONREIMBURSABLE COSTS			
27 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
FACILITY OVERHEAD			
29 FACILITY COSTS	3,600		3,600
30 ADMINISTRATIVE COSTS			
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	3,600		3,600
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	262,080		262,080

RHC 4

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1 PHYSICIAN	82,829	21,045	103,874	
2 PHYSICIAN ASSISTANT				
3 NURSE PRACTITIONER	11,079	2,815	13,894	
4 VISITING NURSE				
5 OTHER NURSE	45,034	11,442	56,476	
6 CLINICAL PSYCHOLOGIST				
7 CLINICAL SOCIAL WORKER				
8 LABORATORY TECHNICIAN				
9 OTHER FACILITY HEALTH CARE STAFF COSTS	15,097	3,836	18,933	
10 SUBTOTAL (SUM OF LINES 1-9)	154,039	39,138	193,177	
COSTS UNDER AGREEMENT				
11 PHYSICIAN SERVICES UNDER AGREEMENT				
12 PHYSICIAN SUPERVISION UNDER AGREEMENT		12,517	12,517	
13 OTHER COSTS UNDER AGREEMENT				
14 SUBTOTAL (SUM OF LINES 11-13)		12,517	12,517	
OTHER HEALTH CARE COSTS				
15 MEDICAL SUPPLIES		2,899	2,899	
16 TRANSPORTATION (HEALTH CARE STAFF)				
17 DEPRECIATION-MEDICAL EQUIPMENT				
18 PROFESSIONAL LIABILITY INSURANCE				
19 OTHER HEALTH CARE COSTS		6,580	6,580	
20 ALLOWABLE GME COSTS				
21 SUBTOTAL (SUM OF LINES 15-20)		9,479	9,479	
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	154,039	61,134	215,173	
COSTS OTHER THAN RHC/FQHC SERVICES				
23 PHARMACY				
24 DENTAL				
25 OPTOMETRY				
26 ALL OTHER NONREIMBURSABLE COSTS				
27 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
FACILITY OVERHEAD				
29 FACILITY COSTS				
30 ADMINISTRATIVE COSTS				
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)				
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	154,039	61,134	215,173	

RHC 4

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS			
1 PHYSICIAN	103,874		103,874
2 PHYSICIAN ASSISTANT			
3 NURSE PRACTITIONER	13,894		13,894
4 VISITING NURSE			
5 OTHER NURSE	56,476		56,476
6 CLINICAL PSYCHOLOGIST			
7 CLINICAL SOCIAL WORKER			
8 LABORATORY TECHNICIAN			
9 OTHER FACILITY HEALTH CARE STAFF COSTS	18,933		18,933
10 SUBTOTAL (SUM OF LINES 1-9)	193,177		193,177
COSTS UNDER AGREEMENT			
11 PHYSICIAN SERVICES UNDER AGREEMENT			
12 PHYSICIAN SUPERVISION UNDER AGREEMENT	12,517		12,517
13 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)	12,517		12,517
OTHER HEALTH CARE COSTS			
15 MEDICAL SUPPLIES	2,899		2,899
16 TRANSPORTATION (HEALTH CARE STAFF)			
17 DEPRECIATION-MEDICAL EQUIPMENT			
18 PROFESSIONAL LIABILITY INSURANCE			
19 OTHER HEALTH CARE COSTS	6,580		6,580
20 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	9,479		9,479
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	215,173		215,173
COSTS OTHER THAN RHC/FQHC SERVICES			
23 PHARMACY			
24 DENTAL			
25 OPTOMETRY			
26 ALL OTHER NONREIMBURSABLE COSTS			
27 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
FACILITY OVERHEAD			
29 FACILITY COSTS			
30 ADMINISTRATIVE COSTS			
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)			
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	215,173		215,173

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO: 14-1300
 COMPONENT NO: 14-3403
 PERIOD: FROM 9/1/2009 TO 8/31/2010
 PREPARED 2/14/2011
 WORKSHEET M-2

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS	.04	4,200	168
2	PHYSICIAN ASSISTANTS		2,100	
3	NURSE PRACTITIONERS	.97	1,720	2,037
4	SUBTOTAL (SUM OF LINES 1-3)	1.01	1,720	2,205
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.01	1,720	
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)	135,928		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)			
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	135,928		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	54,150		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	54,150		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	54,150		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	54,150		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	190,078		
		GREATER OF COL. 2 OR COL. 4		
		5		
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	2,205		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2,205		
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

PROVIDER NO: 14-1300
COMPONENT NO: 14-3475
PERIOD: FROM 9/1/2009 TO 8/31/2010
PREPARED 2/14/2011
WORKSHEET M-2

RHC 2

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS		4,200	
2	PHYSICIAN ASSISTANTS	1.79	2,100	3,759
3	NURSE PRACTITIONERS	.94	2,100	1,974
4	SUBTOTAL (SUM OF LINES 1-3)	2.73	5,993	5,733
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.73	5,993	
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)	343,225		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)			
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	343,225		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	157,863		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	157,863		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	157,863		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	157,863		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	501,088		
		GREATER OF COL. 2 OR COL. 4		
		5		
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	5,993		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	5,993		
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

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	2/14/2011
COMPONENT NO:	TO 8/31/2010	WORKSHEET M-2
14-3474		

RHC 3

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS	1.12	3,216	4,200
2	PHYSICIAN ASSISTANTS	.13	199	2,100
3	NURSE PRACTITIONERS			2,100
4	SUBTOTAL (SUM OF LINES 1-3)	1.25	3,415	4,977
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.25	3,415	
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)	258,480		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)			
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	258,480		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	3,600		
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	96,359		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	99,959		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	99,959		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	99,959		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	358,439		
		GREATER OF COL. 2 OR COL. 4 5		
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	4,977		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4,977		
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

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	2/14/2011
COMPONENT NO:	TO 8/31/2010	WORKSHEET M-2
14-3476		

RHC 4

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS	.42	1,364	4,200
2	PHYSICIAN ASSISTANTS			2,100
3	NURSE PRACTITIONERS	.18	512	2,100
4	SUBTOTAL (SUM OF LINES 1-3)	.60	1,876	
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	.60	1,876	
9	PHYSICIAN SERVICES UNDER AGREEMENTS			1,764
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	215,173		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)			
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	215,173		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	76,338		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	76,338		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	76,338		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	76,338		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	291,511		
			GREATER OF COL. 2 OR COL. 4 5	
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	2,142		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2,142		
9	PHYSICIAN SERVICES UNDER AGREEMENTS			

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

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	190,078
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	2,029
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	188,049
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	2,205
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,205
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	85.28

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)	85.28
10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	253
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	21,576
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)*	21,576
16.01	PRIMARY PAYER AMOUNT	
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	4,561
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	17,015
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	13,612
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	1,354
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	14,966
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	14,966
25	INTERIM PAYMENTS	12,235
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	2,731
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, CHAPTER I, SECTION 115.2	

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

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

TITLE XVII 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)	501,088
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	2,108
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	498,980
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	5,993
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,993
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	83.26

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1
	1	2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	83.26
10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	522
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	43,462
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)*	43,462
16.01	PRIMARY PAYER AMOUNT	36
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	6,631
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	36,795
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	29,436
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	502
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	29,938
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	29,938
25	INTERIM PAYMENTS	26,165
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	3,773
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, CHAPTER I, SECTION 115.2	

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

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

TITLE XVII I RHC 3

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES		UCATION PASS THROUGH COST.
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	358,439
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	5,661
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	352,778
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	4,977
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,977
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	70.88

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)	70.88
10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	1,045
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	74,070
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)*	74,070
16.01	PRIMARY PAYER AMOUNT	127
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	13,686
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	60,257
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	48,206
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	3,657
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	51,863
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	51,863
25	INTERIM PAYMENTS	45,088
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	6,775
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, CHAPTER I, SECTION 115.2	

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

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

TITLE XVII RHC 4

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES EDUCATION PASS THROUGH COST.

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	291,511
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	2,032
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	289,479
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	2,142
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,142
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	135.14

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1
	1	2

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	135.14	135.14
10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		635
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		85,814
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)*		85,814
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		10,480
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		75,334
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		60,267
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		1,133
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		61,400
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		61,400
25	INTERIM PAYMENTS		25,616
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		35,784
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, CHAPTER 1, 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

PROVIDER NO: 14-1300
 COMPONENT NO: 14-3403
 PERIOD: FROM 9/1/2009 TO 8/31/2010
 PREPARED 2/14/2011 WORKSHEET M-4

TITLE XVII I

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)	117,821	117,821	117,821	117,821
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000763	.004298		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	90	506		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	23	832		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	113	1,338		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	135,928	135,928	135,928	135,928
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	54,150	54,150	54,150	54,150
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000831	.009843		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	45	533		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	158	1,871		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	2	72		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	79.00	25.99		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	2	46		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	158	1,196		
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)		2,029		
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)		1,354		

TITLE XVII I 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)	333,782	333,782	333,782	333,782
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000020	.000773		
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	7	258		
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	12	1,167		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	19	1,425		
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	343,225	343,225	343,225	343,225
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	157,863	157,863	157,863	157,863
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000055	.004152		
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	9	655		
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	28	2,080		
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	1	101		
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	28.00	20.59		
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	1	23		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	28	474		
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)		2,108		
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)		502		

TITLE XVII I

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)	246,097	246,097	246,097	246,097
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000649	.008551	.000020	
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	160	2,104	5	
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	219	1,594		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	379	3,698	5	
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	258,480	258,480	258,480	258,480
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	99,959	99,959	99,959	99,959
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.001466	.014307	.000019	
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	147	1,430	2	
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	526	5,128	7	
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	19	138	1	
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	27.68	37.16	7.00	
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	18	85		
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	498	3,159		
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)		5,661		
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)		3,657		

TITLE XVII I RHC 4

	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)	193,177	193,177	193,177	193,177
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000020	.003839	.000020	
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	4	742	4	
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	69	681		
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	73	1,423	4	
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	215,173	215,173	215,173	215,173
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	76,338	76,338	76,338	76,338
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000339	.006613	.000019	
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	26	505	1	
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	99	1,928	5	
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	6	59	4	
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	16.50	32.68	1.25	
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	1	34	4	
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	17	1,111	5	
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)		2,032		
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)		1,133		

RHC 1

DESCRIPTION	PART B	
	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1	12,235
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)		
ADJUSTMENTS TO PROVIDER .01		
ADJUSTMENTS TO PROVIDER .02		
ADJUSTMENTS TO PROVIDER .03		
ADJUSTMENTS TO PROVIDER .04		
ADJUSTMENTS TO PROVIDER .05		
ADJUSTMENTS TO PROGRAM .50		
ADJUSTMENTS TO PROGRAM .51		
ADJUSTMENTS TO PROGRAM .52		
ADJUSTMENTS TO PROGRAM .53		
ADJUSTMENTS TO PROGRAM .54		
ADJUSTMENTS TO PROGRAM .99		
SUBTOTAL		NONE
4 TOTAL INTERIM PAYMENTS		12,235
TO BE COMPLETED BY INTERMEDIARY		
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)		
TENTATIVE TO PROVIDER .01		
TENTATIVE TO PROVIDER .02		
TENTATIVE TO PROVIDER .03		
TENTATIVE TO PROGRAM .50		
TENTATIVE TO PROGRAM .51		
TENTATIVE TO PROGRAM .52		
TENTATIVE TO PROGRAM .99		
SUBTOTAL		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		2,731
SETTLEMENT TO PROVIDER .01		
SETTLEMENT TO PROGRAM .02		
7 TOTAL MEDICARE PROGRAM LIABILITY		14,966

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ____/____/____

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

RHC 2

DESCRIPTION	MM/DD/YYYY	PART B	
		AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1		21,786
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	3/ 5/2010		4,379
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			4,379
4 TOTAL INTERIM PAYMENTS			26,165
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)			3,773
SETTLEMENT TO PROVIDER .01			
SETTLEMENT TO PROGRAM .02			
7 TOTAL MEDICARE PROGRAM LIABILITY			29,938

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.

