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 COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1305	PERIOD FROM 7/ 1/2009 TO 6/30/2010	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 11/23/2010 TIME 13:19

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 IMPRISIONMENT 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:
MEMORIAL HOSPITAL ASSOCIATION 14-1305
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING 6/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1	HOSPITAL	0	319,031	781,385		0
3	SWING BED - SNF	0	90,954	0		0
9	RHC	0	0	583		0
9 .01	RHC II	0	0	-14,085		0
100	TOTAL	0	409,985	767,883		0

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

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96 (08/2010)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER NO: 14-1305 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: SOUTH ADAMS STREET P.O. BOX: 160
1.01 CITY: CARTHAGE STATE: IL ZIP CODE: 62321- COUNTY: HANCOCK

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N) V 4	XVIII 5	XIX 6
02.00 HOSPITAL	MEMORIAL HOSPITAL ASSOCIATION	14-1305		8/ 8/2000	N	O	O
04.00 SWING BED - SNF	MEMORIAL HOSPITAL	14-Z305		8/ 8/2000	N	O	N
14.00 HOSPITAL-BASED RHC	BOWEN CLINIC	14-3456		2/ 5/1999	N	O	N
14.01 HOSPITAL-BASED RHC 2	ADAMS STREET CLINIC	14-3405		8/ 1/1995	N	O	N

17	COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2009 TO: 6/30/2010			
		1	2	
18	TYPE OF CONTROL	2		
	TYPE OF HOSPITAL/SUBPROVIDER			
19	HOSPITAL	1		
20	SUBPROVIDER			
	OTHER INFORMATION			
21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.			
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? 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 AMENDENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.			
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).			
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2		Y
21.04	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2		
21.05	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2		
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO.	N		
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)	N	N	
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.	2	N	
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	N		
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.	N		
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.		/ /	/ /
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /	/ /
24	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY)			/ /
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).			/ /

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	N
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	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 8/ 8/2000
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	

		1	2	3	4
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)	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		

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)	Y
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	Y
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N

MISCELLANEOUS COST REPORT INFORMATION

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

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

	TITLE XIX INPATIENT SERVICES		
38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	Y	
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	N	
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	N	
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	N	
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	N	
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).	Y		
40.01	NAME: FI/CONTRACTOR NAME		FI/CONTRACTOR #	
40.02	STREET: P.O. BOX:			
40.03	CITY: STATE: ZIP CODE: -			
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y		
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y		
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N		
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	Y	10/15/2009	
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?	Y		
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?	N		
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?	N		
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).			

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

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

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		
	PREMIUMS:	271,514	
	PAID LOSSES:	0	
	AND/OR SELF INSURANCE:	0	
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

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

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

MULTICAMPUS

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

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

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

SETTLEMENT DATA

63.00	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY).	Y	10/19/2010

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

I PROVIDER NO: 14-1305 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS -- TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	18	6,885	49,680.00		1,255		355
2	HMO					117		
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					597		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	18	6,885	49,680.00		1,852		355
6	INTENSIVE CARE UNIT	4	180	48.00		2		
11	NURSERY							97
12	TOTAL	22	7,065	49,728.00		1,854		452
13	RPCH VISITS							
17	OTHER LONG TERM CARE	57	20,805					
24	RHC -BOWEN					595		
24 01	RHC-WOMEN & FAMILY CLINIC					351		
25	TOTAL	79						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / TITLE XIX OBSERVATION BEDS ADMITTED 5.01	NOT ADMITTED 5.02	O/P VISITS / TOTAL ALL PATS 6	TRIPS -- TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			2,070				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			639				
4	ADULTS & PED-SB NF			33				
5	TOTAL ADULTS AND PEDS			2,742				
6	INTENSIVE CARE UNIT			2				
11	NURSERY			246				
12	TOTAL			2,990				
13	RPCH VISITS							
17	OTHER LONG TERM CARE			15,781				
24	RHC -BOWEN			3,215				
24 01	RHC-WOMEN & FAMILY CLINIC			5,956				
25	TOTAL							
26	OBSERVATION BED DAYS			557	112	445		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV -- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES -- TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					317	123	594
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
6	INTENSIVE CARE UNIT							
11	NURSERY							
12	TOTAL		156.87			317	123	594
13	RPCH VISITS							
17	OTHER LONG TERM CARE		47.20					
24	RHC -BOWEN		4.00					
24 01	RHC-WOMEN & FAMILY CLINIC		6.30					
25	TOTAL		214.37					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

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

PROVIDER NO: 14-1305 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET S-8

COMPONENT NO: 14-3456

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 209 EAST 5TH ST

1.01 CITY: BOWEN STATE: IL ZIP CODE: 62316 COUNTY: HANCOCK

2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

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

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NUMBER
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	PHYSICIAN NAME	HOURS OF SUPERVISION

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

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM	SUNDAY TO	MONDAY FROM	MONDAY TO	TUESDAY FROM	TUESDAY TO	WEDNESDAY FROM	WEDNESDAY TO	THURSDAY FROM	THURSDAY TO	FRIDAY FROM	FRIDAY TO	SATURDAY FROM	SATURDAY TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC			800	1700	800	1800	800	1700	800	1700	800	1600		

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

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

PROVIDER NO: 14-1305 PERIOD: FROM 7/ 1/2009 TO 6/30/2010 PREPARED 11/23/2010

COMPONENT NO: 14-3405 WORKSHEET S-8

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 213 SOUTH ADAMS STREET

1.01 CITY: CARTHAGE STATE: IL ZIP CODE: 62321 COUNTY: HANCOCK

2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

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

PHYSICIAN INFORMATION:

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

	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		

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

FACILITY HOURS OF OPERATIONS (1)

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

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

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(9/1996)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1305 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		1,052,786	1,052,786	-1,016,278	36,508
3.01	0301	NEW CAP REL COSTS-NH BLDG		139,828	139,828	-30,981	108,847
3.02	0302	NEW CAP REL COSTS-BLDG & FIXT (NEW B				2,023,246	2,023,246
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		683,174	683,174	35,379	718,553
4.01	0401	NEW CAP REL COSTS-NH ME				24,585	24,585
5	0500	EMPLOYEE BENEFITS		2,334,276	2,334,276	-57,296	2,276,980
5.01	0501	SHARED HUMAN RESOURCES	57,768	27,692	85,460		85,460
6.01	0660	HOSPITAL ONLY BUS OFF AND A&G	265,209	1,129,457	1,394,666	315,874	1,710,540
6.02	0661	OTHER ADMINISTRATIVE AND GENERAL SHA	828,279	262,509	1,090,788	231	1,091,019
8	0800	OPERATION OF PLANT	134,175	570,785	704,960		704,960
8.01	0801	OPERATION OF PLANT NURSING HOME	83,632	256,531	340,163		340,163
9	0900	LAUNDRY & LINEN SERVICE	1,466	49,035	50,501		50,501
10	1000	HOUSEKEEPING	96,725	51,126	147,851		147,851
10.01	1001	HOUSEKEEPING NURSING HOME	87,892	7,506	95,398		95,398
11	1100	DIETARY	206,145	150,861	357,006	-173,802	183,204
12	1200	CAFETERIA				173,802	173,802
14	1400	NURSING ADMINISTRATION	101,937	10,990	112,927		112,927
15	1500	CENTRAL SERVICES & SUPPLY					
16	1600	PHARMACY					
17	1700	MEDICAL RECORDS & LIBRARY	167,457	20,036	187,493	39,360	226,853
18	1800	SOCIAL SERVICE	16,165		16,165		16,165
20	2000	NONPHYSICIAN ANESTHETISTS	297,025	16,307	313,332		313,332
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,062,223	15,067	1,077,290	114,806	1,192,096
26	2600	INTENSIVE CARE UNIT					
33	3300	NURSERY				121,889	121,889
36	3600	OTHER LONG TERM CARE	1,049,179	973,292	2,022,471	-9,399	2,013,072
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	284,914	114,598	399,512		399,512
39	3900	DELIVERY ROOM & LABOR ROOM	340,975	7,804	348,779	-236,068	112,711
40	4000	ANESTHESIOLOGY					
41	4100	RADIOLOGY-DIAGNOSTIC	425,977	395,235	821,212		821,212
43	4300	RADIOISOTOPE		69,291	69,291		69,291
44	4400	LABORATORY	446,868	744,829	1,191,697		1,191,697
44.02	4401	GEO PSYCH	54,640	213,537	268,177		268,177
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		60,744	60,744		60,744
49	4900	RESPIRATORY THERAPY	163,974	53,518	217,492	1,193	218,685
50	5000	PHYSICAL THERAPY		52,404	52,404		52,404
53	5300	ELECTROCARDIOLOGY		11,417	11,417	-1,193	10,224
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,499	399,811	429,310		429,310
56	5600	DRUGS CHARGED TO PATIENTS	147,159	519,115	666,274		666,274
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	1,701,329	363,790	2,065,119	-234,390	1,830,729
61	6100	EMERGENCY	491,061	599,090	1,090,151	2,231	1,092,382
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.01	4951	DIABETIC EDUCATION	36,136	2,936	39,072		39,072
63.50	6310	RHC -BOWEN	162,440	72,473	234,913	-15,768	219,145
63.51	6311	RHC-WOMEN & FAMILY CLINIC	536,147	327,731	863,878	-29,436	834,442
		OTHER REIMBURS COST CNTRS					
65	6500	AMBULANCE SERVICES					
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		1,116,178	1,116,178	-1,116,178	
90	9000	OTHER CAPITAL RELATED COSTS					
95		SUBTOTALS	9,276,396	12,875,759	22,152,155	-68,193	22,083,962
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES	142,356	78,336	220,692	61,797	282,489
100	7950	NAUVOO APARTMENTS		19,152	19,152	6,396	25,548
100.01	7951	BEAUTY SHOP	7,421	1,337	8,758		8,758
101		TOTAL	9,426,173	12,974,584	22,400,757	-0-	22,400,757

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1305 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT		36,508
3.01	0301	NEW CAP REL COSTS-NH BLDG		108,847
3.02	0302	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-20,407	2,002,839
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		718,553
4.01	0401	NEW CAP REL COSTS-NH ME		24,585
5	0500	EMPLOYEE BENEFITS	-81,595	2,195,385
5.01	0501	SHARED HUMAN RESOURCES		85,460
6.01	0660	HOSPITAL ONLY BUS OFF AND A&G	-458,661	1,251,879
6.02	0661	OTHER ADMINISTRATIVE AND GENERAL SHA	-1,033	1,089,986
8	0800	OPERATION OF PLANT	-75,593	629,367
8.01	0801	OPERATION OF PLANT NURSING HOME		340,163
9	0900	LAUNDRY & LINEN SERVICE		50,501
10	1000	HOUSEKEEPING		147,851
10.01	1001	HOUSEKEEPING NURSING HOME		95,398
11	1100	DIETARY	-81,330	101,874
12	1200	CAFETERIA	-42,666	131,136
14	1400	NURSING ADMINISTRATION		112,927
15	1500	CENTRAL SERVICES & SUPPLY		
16	1600	PHARMACY		
17	1700	MEDICAL RECORDS & LIBRARY	-4,656	222,197
18	1800	SOCIAL SERVICE		16,165
20	2000	NONPHYSICIAN ANESTHETISTS		313,332
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		1,192,096
26	2600	INTENSIVE CARE UNIT		
33	3300	NURSERY	-90	121,799
36	3600	OTHER LONG TERM CARE	-112,912	1,900,160
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		399,512
39	3900	DELIVERY ROOM & LABOR ROOM		112,711
40	4000	ANESTHESIOLOGY		
41	4100	RADIOLOGY-DIAGNOSTIC		821,212
43	4300	RADIOISOTOPE		69,291
44	4400	LABORATORY	-4,069	1,187,628
44.02	4401	GEO PSYCH	-351	267,826
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		60,744
49	4900	RESPIRATORY THERAPY		218,685
50	5000	PHYSICAL THERAPY		52,404
53	5300	ELECTROCARDIOLOGY		10,224
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-7,134	422,176
56	5600	DRUGS CHARGED TO PATIENTS		666,274
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC	-1,174,934	655,795
61	6100	EMERGENCY	-111,682	980,700
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.01	4951	DIABETIC EDUCATION		39,072
63.50	6310	RHC -BOWEN	-3,076	216,069
63.51	6311	RHC-WOMEN & FAMILY CLINIC	-10,374	824,068
		OTHER REIMBURS COST CNTRS		
65	6500	AMBULANCE SERVICES		
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-2,190,563	19,893,399
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800	PHYSICIANS' PRIVATE OFFICES		282,489
100	7950	NAUVOO APARTMENTS		25,548
100.01	7951	BEAUTY SHOP		8,758
101		TOTAL	-2,190,563	20,210,194

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
I 14-1305 I FROM 7/ 1/2009 I NOT A CMS WORKSHEET
I I TO 6/30/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
3.01	NEW CAP REL COSTS-NH BLDG	0301	NEW CAP REL COSTS-BLDG & FIXT
3.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0302	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
4.01	NEW CAP REL COSTS-NH ME	0401	NEW CAP REL COSTS-MVBLE EQUIP
5	EMPLOYEE BENEFITS	0500	
5.01	SHARED HUMAN RESOURCES	0501	EMPLOYEE BENEFITS
6.01	HOSPITAL ONLY BUS OFF AND A&G	0660	OTHER ADMINISTRATIVE AND GENERAL
6.02	OTHER ADMINISTRATIVE AND GENERAL SHA	0661	OTHER ADMINISTRATIVE AND GENERAL
8	OPERATION OF PLANT	0800	
8.01	OPERATION OF PLANT NURSING HOME	0801	OPERATION OF PLANT
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
10.01	HOUSEKEEPING NURSING HOME	1001	HOUSEKEEPING
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
43	RADIOISOTOPE	4300	
44	LABORATORY	4400	
44.02	GEO PSYCH	4401	LABORATORY
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
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
63.01	DIABETIC EDUCATION	4951	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RHC -BOWEN	6310	RURAL HEALTH CLINIC #####
63.51	RHC-WOMEN & FAMILY CLINIC	6311	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	NAUVOO APARTMENTS	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	BEAUTY SHOP	7951	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

	EXPLANATION OF RECLASSIFICATION	CODE (1) 1	COST CENTER 2	LINE NO 3	INCREASE SALARY 4	INCREASE OTHER 5
1	TO RECLASS DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-NH ME	4.01		24,585
2			NEW CAP REL COSTS-BLDG & FIXT (NEW B	3.02		1,013,708
3			NAUVOO APARTMENTS	100		6,396
4	TO RECLASS CAFETERIA	B	CAFETERIA	12	100,358	73,444
5	TO RECLASS RHC DEPR EXPENSE	C	RHC -BOWEN	63.50		2,570
6	TO RECLASS NURSING EXPENSE	D	OTHER ADMINISTRATIVE AND GENERAL SHA	6.02	231	
7	TO RECLASS INTEREST	E	NEW CAP REL COSTS-MVBLE EQUIP	4		35,379
8			HOSPITAL ONLY BUS OFF AND A&G	6.01		71,261
9			NEW CAP REL COSTS-BLDG & FIXT (NEW B	3.02		1,009,538
10	TO RECLASS DELIVERY AND LABOR	F	ADULTS & PEDIATRICS	25	111,624	2,555
11			NURSERY	33	119,162	2,727
12	TO RECLASS BILLING & TRANSCRIP EXP	G	MEDICAL RECORDS & LIBRARY	17		39,360
13			HOSPITAL ONLY BUS OFF AND A&G	6.01	244,613	
14						
15						
16						
17	TO RECLASS EKG TIME	H	ELECTROCARDIOLOGY	53	7,708	
18			RESPIRATORY THERAPY	49		8,901
19	TO RECLASS DR LYNCH AND JONES TIME	I	RHC-WOMEN & FAMILY CLINIC	63.51	72,625	4,632
20			PHYSICIANS' PRIVATE OFFICES	98	83,048	
21	RECLASS S WATSON TO SWING	J	ADULTS & PEDIATRICS	25	627	
22	RECLASS ALLOWABLE PHYSICIAN FICA	K	CLINIC	60	55,065	
23			EMERGENCY	61	2,231	
24	TO RECLASS CLINIC CAFETERIA COSTS	L	CLINIC	60		8,541
36	TOTAL RECLASSIFICATIONS				797,292	2,303,597

(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.

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	DECREASE SALARY	DECREASE OTHER	A-7 REF
		1	6	7	8	9	10
1	TO RECLASS DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-NH BLDG	3.01		24,585	9
2			NEW CAP REL COSTS-BLDG & FIXT	3		1,013,708	9
3			NEW CAP REL COSTS-NH BLDG	3.01		6,396	9
4	TO RECLASS CAFETERIA	B	DIETARY	11	100,358	73,444	
5	TO RECLASS RHC DEPR EXPENSE	C	NEW CAP REL COSTS-BLDG & FIXT	3		2,570	9
6	TO RECLASS NURSING EXPENSE	D	OTHER LONG TERM CARE	36	231		
7	TO RECLASS INTEREST	E	INTEREST EXPENSE	88		1,116,178	11
8							
9							11
10	TO RECLASS DELIVERY AND LABOR	F	DELIVERY ROOM & LABOR ROOM	39	111,624	2,555	
11			DELIVERY ROOM & LABOR ROOM	39	119,162	2,727	
12	TO RECLASS BILLING & TRANSCRIP EXP	G	CLINIC	60		39,360	
13			CLINIC	60	181,379		
14			RHC -BOWEN	63.50	18,338		
15			RHC-WOMEN & FAMILY CLINIC	63.51	23,645		
16			PHYSICIANS' PRIVATE OFFICES	98	21,251		
17	TO RECLASS EKG TIME	H	RESPIRATORY THERAPY	49	7,708		
18			ELECTROCARDIOLOGY	53		8,901	
19	TO RECLASS DR LYNCH AND JONES TIME	I	CLINIC	60	72,625	4,632	
20			RHC-WOMEN & FAMILY CLINIC	63.51	83,048		
21	RECLASS S WATSON TO SWING	J	OTHER LONG TERM CARE	36	627		
22	RECLASS ALLOWABLE PHYSICIAN FICA	K	EMPLOYEE BENEFITS	5	57,296		
23							
24	TO RECLASS CLINIC CAFETERIA COSTS	L	OTHER LONG TERM CARE	36		8,541	
36	TOTAL RECLASSIFICATIONS				797,292	2,303,597	

(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.

RECLASS CODE: A
EXPLANATION : TO RECLASS DEPRECIATION EXPENSE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-NH ME	4.01	24,585	NEW CAP REL COSTS-NH BLDG	3.01	24,585
2.00	NEW CAP REL COSTS-BLDG & FIXT	3.02	1,013,708	NEW CAP REL COSTS-BLDG & FIXT	3	1,013,708
3.00	NAUVOO APARTMENTS	100	6,396	NEW CAP REL COSTS-NH BLDG	3.01	6,396
TOTAL RECLASSIFICATIONS FOR CODE A			1,044,689			1,044,689

RECLASS CODE: B
EXPLANATION : TO RECLASS CAFETERIA

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	173,802	DIETARY	11	173,802
TOTAL RECLASSIFICATIONS FOR CODE B			173,802			173,802

RECLASS CODE: C
EXPLANATION : TO RECLASS RHC DEPR EXPENSE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RHC -BOWEN	63.50	2,570	NEW CAP REL COSTS-BLDG & FIXT	3	2,570
TOTAL RECLASSIFICATIONS FOR CODE C			2,570			2,570

RECLASS CODE: D
EXPLANATION : TO RECLASS NURSING EXPENSE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER ADMINISTRATIVE AND GENER	6.02	231	OTHER LONG TERM CARE	36	231
TOTAL RECLASSIFICATIONS FOR CODE D			231			231

RECLASS CODE: E
EXPLANATION : TO RECLASS INTEREST

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	35,379	INTEREST EXPENSE	88	1,116,178
2.00	HOSPITAL ONLY BUS OFF AND A&G	6.01	71,261			0
3.00	NEW CAP REL COSTS-BLDG & FIXT	3.02	1,009,538			0
TOTAL RECLASSIFICATIONS FOR CODE E			1,116,178			1,116,178

RECLASS CODE: F
EXPLANATION : TO RECLASS DELIVERY AND LABOR

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	114,179	DELIVERY ROOM & LABOR ROOM	39	114,179
2.00	NURSERY	33	121,889	DELIVERY ROOM & LABOR ROOM	39	121,889
TOTAL RECLASSIFICATIONS FOR CODE F			236,068			236,068

RECLASS CODE: G
EXPLANATION : TO RECLASS BILLING & TRANSCRIP EXP

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL RECORDS & LIBRARY	17	39,360	CLINIC	60	39,360
2.00	HOSPITAL ONLY BUS OFF AND A&G	6.01	244,613	CLINIC	60	181,379
3.00			0	RHC -BOWEN	63.50	18,338
4.00			0	RHC-WOMEN & FAMILY CLINIC	63.51	23,645
5.00			0	PHYSICIANS' PRIVATE OFFICES	98	21,251
TOTAL RECLASSIFICATIONS FOR CODE G			283,973			283,973

RECLASS CODE: H
EXPLANATION : TO RECLASS EKG TIME

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	7,708	RESPIRATORY THERAPY	49	7,708
2.00	RESPIRATORY THERAPY	49	8,901	ELECTROCARDIOLOGY	53	8,901
TOTAL RECLASSIFICATIONS FOR CODE H			16,609			16,609

RECLASS CODE: I
EXPLANATION : TO RECLASS DR LYNCH AND JONES TIME

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RHC-WOMEN & FAMILY CLINIC	63.51	77,257	CLINIC	60	77,257
2.00	PHYSICIANS' PRIVATE OFFICES	98	83,048	RHC-WOMEN & FAMILY CLINIC	63.51	83,048
TOTAL RECLASSIFICATIONS FOR CODE I			160,305			160,305

RECLASS CODE: J
EXPLANATION : RECLASS S WATSON TO SWING

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	627	OTHER LONG TERM CARE	36	627
TOTAL RECLASSIFICATIONS FOR CODE J			627			627

RECLASS CODE: K
EXPLANATION : RECLASS ALLOWABLE PHYSICIAN FICA

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CLINIC	60	55,065	EMPLOYEE BENEFITS	5	57,296
2.00	EMERGENCY	61	2,231			0
TOTAL RECLASSIFICATIONS FOR CODE K			57,296			57,296

RECLASS CODE: L
EXPLANATION : TO RECLASS CLINIC CAFETERIA COSTS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CLINIC	60	8,541	OTHER LONG TERM CARE	36	8,541
TOTAL RECLASSIFICATIONS FOR CODE L			8,541			8,541

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND	521,757					521,757	
2	LAND IMPROVEMENTS	276,320	199,304		199,304	133,744	341,880	
3	BUILDINGS & FIXTURE	5,715,249	21,104,942		21,104,942	3,279,127	23,541,064	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	6,809,500	1,349,273		1,349,273	1,544,466	6,614,307	
7	SUBTOTAL	13,322,826	22,653,519		22,653,519	4,957,337	31,019,008	
8	RECONCILING ITEMS							
9	TOTAL	13,322,826	22,653,519		22,653,519	4,957,337	31,019,008	

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(12/1999)
RECONCILIATION OF CAPITAL COSTS CENTERS I PROVIDER NO: I PERIOD: I PREPARED 11/23/2010
I 14-1305 I FROM 7/ 1/2009 I WORKSHEET A-7
I I TO 6/30/2010 I PARTS III & IV

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	341,880		341,880	.011022				
3 01	NEW CAP REL COSTS-NH	3,788,440		3,788,440	.122133				
3 02	NEW CAP REL COSTS-BL	20,274,381		20,274,381	.653611				
4	NEW CAP REL COSTS-MV	6,083,212		6,083,212	.196112				
4 01	NEW CAP REL COSTS-NH	531,095		531,095	.017122				
5	TOTAL	31,019,008		31,019,008	1.000000				

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	36,508						36,508
3 01	NEW CAP REL COSTS-NH	108,847						108,847
3 02	NEW CAP REL COSTS-BL	1,012,945		989,894				2,002,839
4	NEW CAP REL COSTS-MV	683,174		35,379				718,553
4 01	NEW CAP REL COSTS-NH	24,585						24,585
5	TOTAL	1,866,059		1,025,273				2,891,332

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	1,052,786						1,052,786
3 01	NEW CAP REL COSTS-NH	139,828						139,828
3 02	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV	683,174						683,174
4 01	NEW CAP REL COSTS-NH							
5	TOTAL	1,875,788						1,875,788

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

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER	B	-763	NEW CAP REL COSTS-BLDG &	3.02	9
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES	A	-2,875	HOSPITAL ONLY BUS OFF AND	6.01	
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,230,963			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-75,593			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-42,666	CAFETERIA	12	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-4,656	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES	B	-1,472	DIETARY	11	
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	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	RENT INCOME	B	-11,730	CLINIC	60	
38	DR SPACE	B	-5,120	CLINIC	60	
39	IT MISC REVENUE	B	-1,033	OTHER ADMINISTRATIVE AND	6.02	
40	LOBBYING	A	-7,804	HOSPITAL ONLY BUS OFF AND	6.01	
41	CHILDBIRTH CLASSES	B	-40	HOSPITAL ONLY BUS OFF AND	6.01	
42	PHYS RECRUITMENT	A	-3,061	HOSPITAL ONLY BUS OFF AND	6.01	
43	ADVERTISING - HOSPITAL	A	-51,166	HOSPITAL ONLY BUS OFF AND	6.01	
44	ADVERTSING- BOWEN	A	-3,076	RHC -BOWEN	63.50	
45	ADVERTISING - CLINIC	A	-10,494	CLINIC	60	
46	SUPPLIES SOLD	A	-7,134	MEDICAL SUPPLIES CHARGED	55	
47	PROFESSIONL LIABILITY	A	-103,476	CLINIC	60	
48	UNNECESSARY BORROWING	A	-19,644	NEW CAP REL COSTS-BLDG &	3.02	11
49	NURSING HOME MEALS	B	-79,858	DIETARY	11	
49.01	BABY PICTURE REVENUE	B	-90	NURSERY	33	
49.02	RENTAL INCOME - MIDWEST	B	-6,428	CLINIC	60	
49.03	RENTAL INCOME MISC	B	-42,320	HOSPITAL ONLY BUS OFF AND	6.01	
49.04	MISC INCOME	B	-8,754	HOSPITAL ONLY BUS OFF AND	6.01	
49.05	ADVERTISING - WOMENS	A	-6,774	RHC-WOMEN & FAMILY CLINIC	63.51	
49.06	RENTAL INCOME WOMEN'S CLINIC	B	-3,600	RHC-WOMEN & FAMILY CLINIC	63.51	
49.07	MISC INCOME - PRAIRIE CARDIOVASCULAR	B	-4,069	LABORATORY	44	
49.08	PURCHASE DISCOUNTS	B	-63,345	HOSPITAL ONLY BUS OFF AND	6.01	
49.09	MISC INCOME - GERO PHYS	B	-351	GEO PSYCH	44.02	
49.10	PROVIDER TAX	A	-168,153	HOSPITAL ONLY BUS OFF AND	6.01	
49.11	CAPITAL CAMPAIGN FUND RAISING	A	-3,868	HOSPITAL ONLY BUS OFF AND	6.01	
49.14	MISC INCOME	B	-15,915	OTHER LONG TERM CARE	36	
49.15	MARKETING SALARIES	A	-53,359	HOSPITAL ONLY BUS OFF AND	6.01	
49.16	MARKETING FRINGES	A	-9,717	HOSPITAL ONLY BUS OFF AND	6.01	
49.17	LINE OF CREDIT INTEREST	A	-19,891	HOSPITAL ONLY BUS OFF AND	6.01	
49.18	CITY OF CARTHAGE INTEREST	A	-24,308	HOSPITAL ONLY BUS OFF AND	6.01	
49.19	NURSING HOME DIETARY REVENUE	B	-74,580	OTHER LONG TERM CARE	36	
49.20	NURSING HOME LAUNDRY REVENUE	B	-8,881	OTHER LONG TERM CARE	36	
49.21	NURSING HOME SLF REVENUE	B	-7,686	OTHER LONG TERM CARE	36	
49.22						
49.23						
49.24	NURSING HOME RENTAL INCOME	B	-5,850	OTHER LONG TERM CARE	36	
50	TOTAL (SUM OF LINES 1 THRU 49)		-2,190,563			

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1 8	OPERATION OF PLANT	RENT		75,593	-75,593	
2						
3						
4						
5	TOTALS			75,593	-75,593	

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	C	MEMORIAL HOSPITAL ASSOC.	0.00	HANCOCK COUNTY NURSING	100.00	SNF-NON-CERTIFIED
2			0.00		0.00	
3			0.00		0.00	
4			0.00		0.00	
5			0.00		0.00	

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

Health Financial Systems MCRIF32 FOR MEMORIAL HOSPITAL ASSOCIATION IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1305 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	44	LABORATORY	18,000		18,000				
2	43	RADIOISOTOPE	4,500		4,500				
3	60	CLINIC PHYSICIAN SALARIES	1,037,686	1,037,686					
4	61	ER FEES	788,342	111,682	676,660				
5	5	CLINIC EMPLOYEE BENEFITS	79,056	79,056					
6	5	ER EMPLOYEE BENEFITS	2,539	2,539					
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	1,930,123	1,230,963	699,160				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1305 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	44	LABORATORY							
2	43	RADIOISOTOPE							
3	60	CLINIC PHYSICIAN SALARIES							1,037,686
4	61	ER FEES							111,682
5	5	CLINIC EMPLOYEE BENEFITS							79,056
6	5	ER EMPLOYEE BENEFITS							2,539
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL							1,230,963

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

I PROVIDER NO: I 14-1305 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

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

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		119.75		409.50	
10	AHSEA (SEE INSTRUCTIONS)		70.42		35.21	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	35.21	35.21			
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	8,433
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)	8,433
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	14,418
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)	22,851

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)	70.42
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	54,928
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	69,346

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

STANDARD TRAVEL ALLOWANCE

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)

PHYSICAL THERAPY

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	69,346
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	69,346
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	30,905

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	30,905
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)	30,905
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO: I 14-1305 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

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

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		75.75		241.50	
10	AHSEA (SEE INSTRUCTIONS)		66.74		33.37	
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	33.37	33.37			
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	5,056
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)	5,056
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	8,059
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)	13,115

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	66.75
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	52,065
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	60,124

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

STANDARD TRAVEL ALLOWANCE

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)