

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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET 5
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	14-1324	I	FROM 4/ 1/2009	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 3/31/2010	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 9/ 1/2010 TIME 13:24

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:

FERRELL HOSPITAL 14-1324
FOR THE COST REPORTING PERIOD BEGINNING 4/ 1/2009 AND ENDING 3/31/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1 HOSPITAL	0		-483,829		-58,419	0
3 SWING BED - SNF	0		-5,079		0	0
9 RHC	0		0		51,385	0
9 .01 RHC II	0		0		0	0
100 TOTAL	0		-488,908		-7,034	0

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET S-2
 I I TO 3/31/2010 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 1201 PINE STREET P.O. BOX:
 1.01 CITY: EL DORADO STATE: IL ZIP CODE: 62930- COUNTY: SALINE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00 HOSPITAL	FERRELL HOSPITAL	14-1324		2/ 1/2003	N	O	N
04.00 SWING BED - SNF	FERRELL S/B SNF	14-2324		2/ 1/2003	N	O	N
14.00 HOSPITAL-BASED RHC	ELDORADO	14-8507		4/ 1/2009	N	O	N
14.01 HOSPITAL-BASED RHC 2	RIDGWAY	14-8506		4/ 1/2009	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 4/ 1/2009 TO: 3/31/2010

18 TYPE OF CONTROL

1 2
2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL
20 SUBPROVIDER

1

OTHER INFORMATION

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

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

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

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

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). / /

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET S-2
 I I TO 3/31/2010 I

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.

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / / 0
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / / / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 2/ 1/2003

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

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 1 2 3 4

 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)

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET S-2
 I I TO 3/31/2010 I

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL
 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) V XVIII XIX
 1 2 3
 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? N N N

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). N

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

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

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

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

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

54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N

55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

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. DATE Y OR N LIMIT Y OR N FEES
 0 1 2 3 4
 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. N 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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX
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I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
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I I TO 3/31/2010 I

- 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 OIFFERENT 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). / /

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
I 14-1324 I FROM 4/ 1/2009 I WORKSHEET S-3
I I TO 3/31/2010 I PART I

COMPONENT		NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	I/P DAYS / TITLE V	O/P VISITS / TITLE XVIII	NOT LTCH N/A	TRIPS / TITLE XIX
1	ADULTS & PEDIATRICS	25	9,125	62,400.00	3	4	4.01	5
2	HMO					1,790		381
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					588		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	25	9,125	62,400.00		2,378		381
12	TOTAL	25	9,125	62,400.00		2,378		381
13	RPCH VISITS							
24	RURAL HEALTH CLINIC					866		
25	TOTAL	25						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

COMPONENT		TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL OBSERVATION BEDS ADMITTED	INTERNS & RES. / TOTAL	FTES / LESS I&R REPL NON-PHYS ANES
1	ADULTS & PEDIATRICS	5.01	5.02	6	6.01	7	8
2	HMO			2,600			
2	01 HMO - (IRF PPS SUBPROVIDER)						
3	ADULTS & PED-SB SNF			588			
4	ADULTS & PED-SB NF						
5	TOTAL ADULTS AND PEDS			3,188			
12	TOTAL			3,188			
13	RPCH VISITS						
24	RURAL HEALTH CLINIC			5,524			
25	TOTAL						
26	OBSERVATION BED DAYS			730		730	
27	AMBULANCE TRIPS						
28	EMPLOYEE DISCOUNT DAYS						
28	01 EMP DISCOUNT DAYS -IRF						
29	LABOR & DELIVERY DAYS						

COMPONENT		I & R FTES NET	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1	ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2	HMO					465	134	763
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		156.54			465	134	763
13	RPCH VISITS							
24	RURAL HEALTH CLINIC			5.17				
25	TOTAL		161.71					
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

IN LIEU OF FORM CMS-2552-96 S-8 (09/2000)
I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
I 14-1324 I FROM 4/ 1/2009 I WORKSHEET S-8
I COMPONENT NO: I TO 3/31/2010 I
I 14-8507 I I

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 1201 PINE STREET
1.01 CITY: EL DORADO STATE: IL ZIP CODE: 62930 COUNTY: SALINE
2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
12 CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14
			730	1600	730	1600	700	1900	800	1630	730	1130		

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

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

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

15 PROVIDER NAME: RIDGEWAY PROVIDER NUMBER: 148506

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

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

HOSPITAL UNCOMPENSATED CARE DATA

I IN LIEU OF FORM CMS-2552-96 S-10 (05/2004)
 I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET S-10
 I I TO 3/31/2010 I
 I I I

DESCRIPTION

UNCOMPENSATED CARE INFORMATION		
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
UNCOMPENSATED CARE REVENUES		
17	REVENUE FROM UNCOMPENSATED CARE	252,654
17.01	GROSS MEDICAID REVENUES	1,149,843
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	19,061
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	1,421,558
UNCOMPENSATED CARE COST		
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.505487
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	

HOSPITAL UNCOMPENSATED CARE DATA

IN LIEU OF FORM CMS-2552-96 S-10 (05/2004)
 I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET S-10
 I I TO 3/31/2010 I
 I I I

DESCRIPTION

28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	4,005,435
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	2,024,695
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	1,651,643
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	834,884
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	2,024,695

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 14-1324
II PERIOD:
I FROM 4/ 1/2009
I TO 3/31/2010
II PREPARED 9/ 1/2010
I WORKSHEET A
I

	COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		830,002	830,002	-260,487	569,515
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				283,025	283,025
5	0500	EMPLOYEE BENEFITS	115,924	1,661,617	1,777,541		1,777,541
6	0600	ADMINISTRATIVE & GENERAL	756,730	1,796,396	2,553,126	-76,464	2,476,662
7	0700	MAINTENANCE & REPAIRS	163,861	118,153	282,014		282,014
8	0800	OPERATION OF PLANT		219,246	219,246	97,749	316,995
9	0900	LAUNDRY & LINEN SERVICE	39,611	22,506	62,117		62,117
10	1000	HOUSEKEEPING	171,868	23,044	194,912		194,912
11	1100	DIETARY	187,406	161,264	348,670	-111,993	236,677
12	1200	CAFETERIA				111,928	111,928
14	1400	NURSING ADMINISTRATION	134,430	9,304	143,734		143,734
17	1700	MEDICAL RECORDS & LIBRARY	191,823	24,382	216,205		216,205
20	2000	NONPHYSICIAN ANESTHETISTS					
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,270,008	79,710	1,349,718	-20,298	1,329,420
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	234,905	58,511	293,416	-2,336	291,080
40	4000	ANESTHESIOLOGY	66,986	145,224	212,210		212,210
41	4100	RADIOLOGY-DIAGNOSTIC	416,982	613,122	1,030,104	-188	1,029,916
44	4400	LABORATORY	453,589	415,112	868,701		868,701
49	4900	RESPIRATORY THERAPY	316,380	64,382	380,762		380,762
50	5000	PHYSICAL THERAPY	224,856	45,850	270,706	-3,601	267,105
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	92,934	199,696	292,630	3,395	296,025
56	5600	DRUGS CHARGED TO PATIENTS	187,127	555,456	742,583	1	742,584
59	3950	OTHER ANCILLARY SERVICE COST CENTERS	381,018	77,326	458,344		458,344
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	329,997	134,077	464,074	-4,666	459,408
61	6100	EMERGENCY	429,599	678,069	1,107,668	-807	1,106,861
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4040	FAMILY PRACTICE					
63.50	6310	RURAL HEALTH CLINIC	300,473	58,905	359,378	-11,362	348,016
		SPEC PURPOSE COST CENTERS					
95		SUBTOTALS	6,466,507	7,991,354	14,457,861	3,896	14,461,757
		NONREIMBURS COST CENTERS					
98	9800	PHYSICIANS' PRIVATE OFFICES	327,761	115,849	443,610	-3,896	439,714
98.01	9801	MARKETING	66,028	184,749	250,777		250,777
101		TOTAL	6,860,296	8,291,952	15,152,248	-0-	15,152,248

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:	I PERIOD:	I PREPARED
I 14-1324	I FROM 4/ 1/2009	I 9/ 1/2010
I	I TO 3/31/2010	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	-10,956	558,559
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		283,025
5	0500	EMPLOYEE BENEFITS		1,777,541
6	0600	ADMINISTRATIVE & GENERAL	-2,466	2,474,196
7	0700	MAINTENANCE & REPAIRS		282,014
8	0800	OPERATION OF PLANT	-7,125	309,870
9	0900	LAUNDRY & LINEN SERVICE		62,117
10	1000	HOUSEKEEPING		194,912
11	1100	DIETARY		236,677
12	1200	CAFETERIA	-37,821	74,107
14	1400	NURSING ADMINISTRATION		143,734
17	1700	MEDICAL RECORDS & LIBRARY	-12,278	203,927
20	2000	NONPHYSICIAN ANESTHETISTS		
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		1,329,420
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		291,080
40	4000	ANESTHESIOLOGY	-212,210	
41	4100	RADIOLOGY-DIAGNOSTIC		1,029,916
44	4400	LABORATORY		868,701
49	4900	RESPIRATORY THERAPY		380,762
50	5000	PHYSICAL THERAPY		267,105
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		296,025
56	5600	DRUGS CHARGED TO PATIENTS	-41,387	701,197
59	3950	OTHER ANCILLARY SERVICE COST CENTERS		458,344
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC		459,408
61	6100	EMERGENCY	-331,102	775,759
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4040	FAMILY PRACTICE		
63.50	6310	RURAL HEALTH CLINIC		348,016
		SPEC PURPOSE COST CENTERS		
95		SUBTOTALS	-655,345	13,806,412
		NONREIMBURS COST CENTERS		
98	9800	PHYSICIANS' PRIVATE OFFICES		439,714
98.01	9801	MARKETING		250,777
101		TOTAL	-655,345	14,496,903

COST CENTERS USED IN COST REPORT

IN LIEU OF FORM CMS-2552-96(7/2009)
 I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I NOT A CMS WORKSHEET
 I I TO 3/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
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	FAMILY PRACTICE	4040	FAMILY PRACTICE
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	SPEC PURPOSE COST CE		
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	MARKETING	9801	PHYSICIANS' PRIVATE OFFICES
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141324	FROM 4/ 1/2009	9/ 1/2010
	TO 3/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE	
	(1)	COST CENTER	LINE NO	
	1	2	3	4
				5
1 RECLASS CAFETERIA EXPENSE	A	CAFETERIA	12	60,160
2 RENT	B	NEW CAP REL COSTS-MVBLE EQUIP	4	51,768
3				22,538
4				
5				
6 DEPRECIATION	C	NEW CAP REL COSTS-MVBLE EQUIP	4	260,487
7 UTILITIES	D	OPERATION OF PLANT	8	97,749
8				
9				
10				
11				
12				
13 MED SUPPLY	E	MEDICAL SUPPLIES CHARGED TO PATIENTS	55	3,395
14				
15				
16				
17 DRUGS	F	DRUGS CHARGED TO PATIENTS	56	1
36 TOTAL RECLASSIFICATIONS				60,160
				435,938

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141324	FROM 4/ 1/2009	9/ 1/2010
	TO 3/31/2010	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE			A-7 REF 10
			LINE NO 7	SALARY 8	OTHER 9	
1 RECLASS CAFETERIA EXPENSE	A	DIETARY	11	60,160	51,768	
2 RENT	B	ADULTS & PEDIATRICS	25		20,298	10
3		CLINIC	60		1,950	
4		PHYSICIANS' PRIVATE OFFICES	98		225	
5		DIETARY	11		65	
6 DEPRECIATION	C	NEW CAP REL COSTS-BLDG & FIXT	3		260,487	9
7 UTILITIES	D					
8		ADMINISTRATIVE & GENERAL	6		76,464	
9		PHYSICAL THERAPY	50		3,601	
10		CLINIC	60		2,716	
11		RURAL HEALTH CLINIC	63.50		11,362	
12		PHYSICIANS' PRIVATE OFFICES	98		3,606	
13 MED SUPPLY	E	OPERATING ROOM	37		2,336	
14		RADIOLOGY-DIAGNOSTIC	41		188	
15		EMERGENCY	61		806	
16		PHYSICIANS' PRIVATE OFFICES	98		65	
17 DRUGS	F	EMERGENCY	61		1	
36 TOTAL RECLASSIFICATIONS				60,160	435,938	

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141324	FROM 4/ 1/2009	9/ 1/2010
	TO 3/31/2010	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : RECLASS CAFETERIA EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	111,928
TOTAL RECLASSIFICATIONS FOR CODE A			111,928

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
DIETARY	11	111,928	
TOTAL RECLASSIFICATIONS FOR CODE A			111,928

RECLASS CODE: B
EXPLANATION : RENT

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	22,538
2.00			0
3.00			0
4.00			0
TOTAL RECLASSIFICATIONS FOR CODE B			22,538

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADULTS & PEDIATRICS	25	20,298	
CLINIC	60	1,950	
PHYSICIANS' PRIVATE OFFICES	98	225	
DIETARY	11	65	
TOTAL RECLASSIFICATIONS FOR CODE B			22,538

RECLASS CODE: C
EXPLANATION : DEPRECIATION

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	260,487
TOTAL RECLASSIFICATIONS FOR CODE C			260,487

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
NEW CAP REL COSTS-BLDG & FIXT	3	260,487	
TOTAL RECLASSIFICATIONS FOR CODE C			260,487

RECLASS CODE: D
EXPLANATION : UTILITIES

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	OPERATION OF PLANT	8	97,749
2.00			0
3.00			0
4.00			0
5.00			0
6.00			0
TOTAL RECLASSIFICATIONS FOR CODE D			97,749

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	76,464	0
PHYSICAL THERAPY	50	3,601	
CLINIC	60	2,716	
RURAL HEALTH CLINIC	63.50	11,362	
PHYSICIANS' PRIVATE OFFICES	98	3,606	
TOTAL RECLASSIFICATIONS FOR CODE D			97,749

RECLASS CODE: E
EXPLANATION : MED SUPPLY

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	3,395
2.00			0
3.00			0
4.00			0
TOTAL RECLASSIFICATIONS FOR CODE E			3,395

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
OPERATING ROOM	37	2,336	
RADIOLOGY-DIAGNOSTIC	41	188	
EMERGENCY	61	806	
PHYSICIANS' PRIVATE OFFICES	98	65	
TOTAL RECLASSIFICATIONS FOR CODE E			3,395

RECLASS CODE: F
EXPLANATION : DRUGS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	1
TOTAL RECLASSIFICATIONS FOR CODE F			1

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
EMERGENCY	61	1	
TOTAL RECLASSIFICATIONS FOR CODE F			1

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	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	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND	155,302					155,302	
2 LAND IMPROVEMENTS	44,285					44,285	
3 BUILDINGS & FIXTURE	2,642,726	16,628		16,628		2,659,354	
4 BUILDING IMPROVEMEN							
5 FIXED EQUIPMENT	2,288,801				44,244	2,244,557	
6 MOVABLE EQUIPMENT							
7 SUBTOTAL	5,131,114	16,628		16,628	44,244	5,103,498	
8 RECONCILING ITEMS							
9 TOTAL	5,131,114	16,628		16,628	44,244	5,103,498	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS 1	CAPITIALIZED GROSS ASSETS LEASES 2	FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	
3	NEW CAP REL COSTS-BL	2,842,313		2,842,313	.553937			
4	NEW CAP REL COSTS-MV	2,288,801		2,288,801	.446063			
5	TOTAL	5,131,114		5,131,114	1.000000			

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	558,559						558,559
4	NEW CAP REL COSTS-MV	260,487	22,538					283,025
5	TOTAL	819,046	22,538					841,584

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	830,002						830,002
4	NEW CAP REL COSTS-MV							
5	TOTAL	830,002						830,002

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

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF.
			COST CENTER	LINE NO	
1			**COST CENTER DELETED**	1	
2			**COST CENTER DELETED**	2	
3	B	-10,956	NEW CAP REL COSTS-BLDG &	3	9
4			NEW CAP REL COSTS-MVBLE E	4	
5					
6					
7					
8	B	-645	ADMINISTRATIVE & GENERAL	6	
9					
10					
11					
12	A-8-2	-331,102			
13	B	-335	ADMINISTRATIVE & GENERAL	6	
14	A-8-1				
15					
16	B	-32,133	CAFETERIA	12	
17	B	-7,125	OPERATION OF PLANT	8	
18					
19	B	-41,387	DRUGS CHARGED TO PATIENTS	56	
20	B	-12,278	MEDICAL RECORDS & LIBRARY	17	
21					
22	B	-5,688	CAFETERIA	12	
23					
24					
25	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	A-8-3				
28			**COST CENTER DELETED**	89	
29			**COST CENTER DELETED**	1	
30			**COST CENTER DELETED**	2	
31			NEW CAP REL COSTS-BLDG &	3	
32			NEW CAP REL COSTS-MVBLE E	4	
33			NONPHYSICIAN ANESTHETISTS	20	
34					
35	A-8-4		**COST CENTER DELETED**	51	
36	A-8-4		**COST CENTER DELETED**	52	
37	A	-212,210	ANESTHESIOLOGY	40	
38	B	-1,486	ADMINISTRATIVE & GENERAL	6	
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
49.01					
49.02					
49.03					
49.04					
49.05					
49.06					
49.07					
49.08					
49.09					
49.10					
49.11					
49.12					
49.13					
50	TOTAL (SUM OF LINES 1 THRU 49)	-655,345			

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET A-8-2
 I I TO 3/31/2010 I GROUP 1

	WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
1	49	CARDIOPULMONARY	1,994		1,994				
2	61	EMERGENCY ROOM	658,413	331,102	327,311				
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	660,407	331,102	329,305				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET A-8-2
 I I TO 3/31/2010 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	49	CARDIOPULMONARY						
2	61	EMERGENCY ROOM						331,102
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101		TOTAL						331,102

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I NOT A CMS WORKSHEET
 I I TO 3/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	-3	ACCUM.	COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	1	SQUARE	FEET	ENTERED
8	OPERATION OF PLANT	1	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	5	PATIENT	DAYS	ENTERED
10	HOUSEKEEPING	1	SQUARE	FEET	ENTERED
11	DIETARY	5	PATIENT	DAYS	ENTERED
12	CAFETERIA	7	HOURS		ENTERED
14	NURSING ADMINISTRATION	9	NURSING	SALARIES	ENTERED
17	MEDICAL RECORDS & LIBRARY	12	GROSS	REVENUE	ENTERED
20	NONPHYSICIAN ANESTHETISTS	15	ASSIGNED	TIME	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET B
 I I TO 3/31/2010 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
	0	3	4	5	5a.00	6	7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	558,559	558,559					
005 NEW CAP REL COSTS-MVBLE E	283,025		283,025				
006 EMPLOYEE BENEFITS	1,777,541			1,777,541			
007 ADMINISTRATIVE & GENERAL	2,474,196	171,089	86,693	199,443	2,931,421	2,931,421	
008 MAINTENANCE & REPAIRS	282,014	20,783	10,531	43,187	356,515	90,363	446,878
009 OPERATION OF PLANT	309,870	26,071	13,210		349,151	88,497	31,773
010 LAUNDRY & LINEN SERVICE	62,117	16,412	8,316	10,440	97,285	24,658	20,001
011 HOUSEKEEPING	194,912	7,051	3,573	45,297	250,833	63,577	8,593
012 DIETARY	236,677	25,035	12,685	33,537	307,934	78,050	30,510
014 CAFETERIA	74,107	3,895	1,973	15,856	95,831	24,290	4,746
017 NURSING ADMINISTRATION	143,734	12,541	6,355	35,430	198,060	50,201	15,284
020 MEDICAL RECORDS & LIBRARY	203,927	6,360	3,223	50,557	264,067	66,931	7,751
025 NONPHYSICIAN ANESTHETISTS							
ADULTS & PEDIATRICS	1,329,420	93,494	47,374	334,723	1,805,011	457,502	113,939
037 ANCILLARY SRVC COST CNTRS							
OPERATING ROOM	291,080	15,400	7,803	61,911	376,194	95,351	18,767
040 ANESTHESIOLOGY		2,978	1,509	17,655	22,142	5,612	3,629
041 RADIOLOGY-DIAGNOSTIC	1,029,916	24,570	12,450	109,899	1,176,835	298,284	29,944
044 LABORATORY	868,701	12,625	6,397	119,547	1,007,270	255,306	15,386
049 RESPIRATORY THERAPY	380,762	23,689	12,003	83,385	499,839	126,691	28,870
050 PHYSICAL THERAPY	267,105	1,429	724	59,263	328,521	83,268	1,742
055 MEDICAL SUPPLIES CHARGED	296,025	4,216	2,136	24,494	326,871	82,850	5,138
056 DRUGS CHARGED TO PATIENTS	701,197	14,518	7,357	49,319	772,391	195,773	17,693
059 OTHER ANCILLARY SERVICE C	458,344	13,101	6,638	100,421	578,504	146,629	15,966
060 OUTPAT SERVICE COST CNTRS							
CLINIC	459,408	18,925	9,589	86,974	574,896	145,715	23,064
061 EMERGENCY	775,759	4,716	2,390	113,225	896,090	227,126	5,748
062 OBSERVATION BEDS (NON-DIS							
063 FAMILY PRACTICE							
063 50 RURAL HEALTH CLINIC	348,016	39,661	20,096	79,192	486,965	123,428	48,334
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	13,806,412	558,559	283,025	1,673,755	13,702,626	2,730,102	446,878
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	439,714			86,384	526,098	133,346	
098 01 MARKETING	250,777			17,402	268,179	67,973	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	14,496,903	558,559	283,025	1,777,541	14,496,903	2,931,421	446,878

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET B
 I I TO 3/31/2010 I PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
	8	9	10	11	12	14	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	469,421						
010 LAUNDRY & LINEN SERVICE	22,618	164,562					
011 HOUSEKEEPING	9,717		332,720				
012 DIETARY	34,502		26,264	477,260			
014 CAFETERIA	5,367		4,086		134,320		
017 NURSING ADMINISTRATION	17,284		13,157			297,738	
020 MEDICAL RECORDS & LIBRARY	8,765		6,672		8,464		362,650
025 NONPHYSICIAN ANESTHETISTS							
037 INPAT ROUTINE SRVC CNTRS							
040 ADULTS & PEDIATRICS	128,849	164,562	98,083	477,260	39,709	223,375	43,023
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM	21,223		16,156		5,893	33,151	22,518
049 ANESTHESIOLOGY	4,103		3,124				10,174
050 RADIOLOGY-DIAGNOSTIC	33,862		25,776		10,569		90,317
055 LABORATORY	17,399		13,244		15,431		64,414
056 RESPIRATORY THERAPY	32,647		24,852		9,450		32,693
059 PHYSICAL THERAPY	1,970		1,499		5,406		11,332
060 MEDICAL SUPPLIES CHARGED	5,811		4,423		3,572		5,476
061 DRUGS CHARGED TO PATIENTS	20,009		15,231		4,508		33,729
062 OTHER ANCILLARY SERVICE C	18,055		13,744		2,744		2,414
063 OUTPAT SERVICE COST CNTRS							
066 CLINIC	26,082		19,854		9,438		21,919
067 EMERGENCY	6,500		4,948		7,326	41,212	24,641
068 OBSERVATION BEDS (NON-DIS							
069 FAMILY PRACTICE							
070 50 RURAL HEALTH CLINIC	54,658		41,607				
071 SPEC PURPOSE COST CENTERS							
072 SUBTOTALS	469,421	164,562	332,720	477,260	126,262	297,738	362,650
073 NONREIMBURS COST CENTERS							
074 PHYSICIANS' PRIVATE OFFIC					6,753		
075 01 MARKETING					1,305		
076 CROSS FOOT ADJUSTMENT							
077 NEGATIVE COST CENTER							
078 TOTAL	469,421	164,562	332,720	477,260	134,320	297,738	362,650

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	20	25	26	27
GENERAL SERVICE COST CNTR				
003 NEW CAP REL COSTS-BLDG &				
004 NEW CAP REL COSTS-MVBLE E				
005 EMPLOYEE BENEFITS				
006 ADMINISTRATIVE & GENERAL				
007 MAINTENANCE & REPAIRS				
008 OPERATION OF PLANT				
009 LAUNDRY & LINEN SERVICE				
010 HOUSEKEEPING				
011 DIETARY				
012 CAFETERIA				
014 NURSING ADMINISTRATION				
017 MEDICAL RECORDS & LIBRARY				
020 NONPHYSICIAN ANESTHETISTS				
INPAT ROUTINE SRVC CNTRS				
025 ADULTS & PEDIATRICS		3,551,313		3,551,313
ANCILLARY SRVC COST CNTRS				
037 OPERATING ROOM		589,253		589,253
040 ANESTHESIOLOGY		48,784		48,784
041 RADIOLOGY-DIAGNOSTIC		1,665,587		1,665,587
044 LABORATORY		1,388,450		1,388,450
049 RESPIRATORY THERAPY		755,042		755,042
050 PHYSICAL THERAPY		433,738		433,738
055 MEDICAL SUPPLIES CHARGED		434,141		434,141
056 DRUGS CHARGED TO PATIENTS		1,059,334		1,059,334
059 OTHER ANCILLARY SERVICE C		778,056		778,056
OUTPAT SERVICE COST CNTRS				
060 CLINIC		820,968		820,968
061 EMERGENCY		1,213,591		1,213,591
062 OBSERVATION BEDS (NON-DIS				
063 FAMILY PRACTICE				
063 50 RURAL HEALTH CLINIC		754,992		754,992
SPEC PURPOSE COST CENTERS				
095 SUBTOTALS		13,493,249		13,493,249
NONREIMBURS COST CENTERS				
098 PHYSICIANS' PRIVATE OFFIC		666,197		666,197
098 01 MARKETING		337,457		337,457
101 CROSS FOOT ADJUSTMENT				
102 NEGATIVE COST CENTER				
103 TOTAL		14,496,903		14,496,903

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET B
 I I TO 3/31/2010 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
	0	3	4	4a	5	6	7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		171,089	86,693	257,782		257,782	
007 MAINTENANCE & REPAIRS		20,783	10,531	31,314		7,946	39,260
008 OPERATION OF PLANT		26,071	13,210	39,281		7,782	2,791
009 LAUNDRY & LINEN SERVICE		16,412	8,316	24,728		2,168	1,757
010 HOUSEKEEPING		7,051	3,573	10,624		5,591	755
011 DIETARY		25,035	12,685	37,720		6,864	2,680
012 CAFETERIA		3,895	1,973	5,868		2,136	417
014 NURSING ADMINISTRATION		12,541	6,355	18,896		4,415	1,343
017 MEDICAL RECORDS & LIBRARY		6,360	3,223	9,583		5,886	681
020 NONPHYSICIAN ANESTHETISTS							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		93,494	47,374	140,868		40,231	10,011
025 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		15,400	7,803	23,203		8,385	1,649
040 ANESTHESIOLOGY		2,978	1,509	4,487		494	319
041 RADIOLOGY-DIAGNOSTIC		24,570	12,450	37,020		26,230	2,631
044 LABORATORY		12,625	6,397	19,022		22,451	1,352
049 RESPIRATORY THERAPY		23,689	12,003	35,692		11,141	2,536
050 PHYSICAL THERAPY		1,429	724	2,153		7,322	153
055 MEDICAL SUPPLIES CHARGED		4,216	2,136	6,352		7,286	451
056 DRUGS CHARGED TO PATIENTS		14,518	7,357	21,875		17,216	1,554
059 OTHER ANCILLARY SERVICE C		13,101	6,638	19,739		12,894	1,403
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC		18,925	9,589	28,514		12,814	2,026
061 EMERGENCY		4,716	2,390	7,106		19,973	505
062 OBSERVATION BEDS (NON-DIS							
063 FAMILY PRACTICE							
063 50 RURAL HEALTH CLINIC		39,661	20,096	59,757		10,854	4,246
063 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		558,559	283,025	841,584		240,079	39,260
095 NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC						11,726	
098 01 MARKETING						5,977	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		558,559	283,025	841,584		257,782	39,260

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET B
 I I TO 3/31/2010 I PART III

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
	8	9	10	11	12	14	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT	49,854						
009 LAUNDRY & LINEN SERVICE	2,402	31,055					
010 HOUSEKEEPING	1,032		18,002				
011 DIETARY	3,664		1,421	52,349			
012 CAFETERIA	570		221		9,212		
014 NURSING ADMINISTRATION	1,836		712		257	27,459	
017 MEDICAL RECORDS & LIBRARY	931		361		580		18,022
020 NONPHYSICIAN ANESTHETISTS							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	13,684	31,055	5,306	52,349	2,726	20,601	2,139
025 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	2,254		874		404	3,057	1,119
040 ANESTHESIOLOGY	436		169				506
041 RADIOLOGY-DIAGNOSTIC	3,596		1,395		725		4,484
044 LABORATORY	1,848		717		1,058		3,202
049 RESPIRATORY THERAPY	3,467		1,345		648		1,625
050 PHYSICAL THERAPY	209		81		371		563
055 MEDICAL SUPPLIES CHARGED	617		239		245		272
056 DRUGS CHARGED TO PATIENTS	2,125		824		309		1,677
059 OTHER ANCILLARY SERVICE C	1,918		744		188		120
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC	2,770		1,074		647		1,090
061 EMERGENCY	690		268		502	3,801	1,225
062 OBSERVATION BEDS (NON-DIS							
063 FAMILY PRACTICE							
063 50 RURAL HEALTH CLINIC	5,805		2,251				
063 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	49,854	31,055	18,002	52,349	8,660	27,459	18,022
095 NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC					463		
098 01 MARKETING					89		
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	49,854	31,055	18,002	52,349	9,212	27,459	18,022

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	20	25	26	27
003 GENERAL SERVICE COST CNTR				
004 NEW CAP REL COSTS-BLDG &				
005 NEW CAP REL COSTS-MVBLE E				
006 EMPLOYEE BENEFITS				
007 ADMINISTRATIVE & GENERAL				
008 MAINTENANCE & REPAIRS				
009 OPERATION OF PLANT				
010 LAUNDRY & LINEN SERVICE				
011 HOUSEKEEPING				
012 DIETARY				
014 CAFETERIA				
017 NURSING ADMINISTRATION				
020 MEDICAL RECORDS & LIBRARY				
025 NONPHYSICIAN ANESTHETISTS				
025 INPAT ROUTINE SRVC CNTRS				
025 ADULTS & PEDIATRICS		318,970		318,970
037 ANCILLARY SRVC COST CNTRS				
040 OPERATING ROOM		40,945		40,945
041 ANESTHESIOLOGY		6,411		6,411
044 RADIOLOGY-DIAGNOSTIC		76,081		76,081
049 LABORATORY		49,650		49,650
050 RESPIRATORY THERAPY		56,454		56,454
055 PHYSICAL THERAPY		10,852		10,852
056 MEDICAL SUPPLIES CHARGED		15,462		15,462
059 DRUGS CHARGED TO PATIENTS		45,580		45,580
060 OTHER ANCILLARY SERVICE C		37,006		37,006
061 OUTPAT SERVICE COST CNTRS				
062 CLINIC		48,935		48,935
063 EMERGENCY		34,070		34,070
063 50 OBSERVATION BEDS (NON-DIS				
063 50 FAMILY PRACTICE				
063 50 RURAL HEALTH CLINIC		82,913		82,913
095 SPEC PURPOSE COST CENTERS				
095 SUBTOTALS		823,329		823,329
098 NONREIMBURS COST CENTERS				
098 01 PHYSICIANS' PRIVATE OFFIC		12,189		12,189
101 01 MARKETING		6,066		6,066
102 CROSS FOOT ADJUSTMENTS				
103 NEGATIVE COST CENTER				
103 TOTAL		841,584		841,584

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET B-1
 I I TO 3/31/2010 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
	OSTS-BLDG & (SQUARE FEET)	OSTS-MVBLE E (SQUARE FEET)	(GROSS SALARIES)		(ACCUM. COST)	(SQUARE FEET)
	3	4	5	6a.00	6	7
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	46,898					
005 NEW CAP REL COSTS-MVB		46,898				
006 EMPLOYEE BENEFITS			6,744,372			
007 ADMINISTRATIVE & GENE	14,365	14,365	756,730	-2,931,421	11,565,482	
008 MAINTENANCE & REPAIRS	1,745	1,745	163,861		356,515	30,788
009 OPERATION OF PLANT	2,189	2,189			349,151	2,189
010 LAUNDRY & LINEN SERVI	1,378	1,378	39,611		97,285	1,378
011 HOUSEKEEPING	592	592	171,868		250,833	592
012 DIETARY	2,102	2,102	127,246		307,934	2,102
013 CAFETERIA	327	327	60,160		95,831	327
014 NURSING ADMINISTRATIO	1,053	1,053	134,430		198,060	1,053
017 MEDICAL RECORDS & LIB	534	534	191,823		264,067	534
020 NONPHYSICIAN ANESTHET						
025 INPAT ROUTINE SRVC CN						
ADULTS & PEDIATRICS	7,850	7,850	1,270,008		1,805,011	7,850
037 ANCILLARY SRVC COST C						
OPERATING ROOM	1,293	1,293	234,905		376,194	1,293
040 ANESTHESIOLOGY	250	250	66,986		22,142	250
041 RADIOLOGY-DIAGNOSTIC	2,063	2,063	416,982		1,176,835	2,063
044 LABORATORY	1,060	1,060	453,589		1,007,270	1,060
049 RESPIRATORY THERAPY	1,989	1,989	316,380		499,839	1,989
050 PHYSICAL THERAPY	120	120	224,856		328,521	120
055 MEDICAL SUPPLIES CHAR	354	354	92,934		326,871	354
056 DRUGS CHARGED TO PATI	1,219	1,219	187,127		772,391	1,219
059 OTHER ANCILLARY SERVI	1,100	1,100	381,018		578,504	1,100
060 OUTPAT SERVICE COST C						
CLINIC	1,589	1,589	329,997		574,896	1,589
061 EMERGENCY	396	396	429,599		896,090	396
062 OBSERVATION BEDS (NON						
063 FAMILY PRACTICE						
063 50 RURAL HEALTH CLINIC	3,330	3,330	300,473		486,965	3,330
095 SPEC PURPOSE COST CEN						
SUBTOTALS	46,898	46,898	6,350,583	-2,931,421	10,771,205	30,788
098 NONREIMBURS COST CENT						
PHYSICIANS' PRIVATE O			327,761		526,098	
098 01 MARKETING			66,028		268,179	
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	558,559	283,025	1,777,541		2,931,421	446,878
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	11.910081		.263559		.253463	
(WRKSHT B, PT I)		6.034906				14.514681
105 COST TO BE ALLOCATED						
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER					257,782	39,260
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED						
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER					.022289	1.275172
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET B-1
 I I TO 3/31/2010 I

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
		(SQUARE FEET)	(PATIENT) DAYS	(SQUARE) FEET	(PATIENT) DAYS	(HOURS)	(NURSING) SALARIES	(GROSS) REVENUE
		8	9	10	11	12	14	17
003	GENERAL SERVICE COST							
004	NEW CAP REL COSTS-BLD							
005	NEW CAP REL COSTS-MVB							
006	EMPLOYEE BENEFITS							
007	ADMINISTRATIVE & GENE							
008	MAINTENANCE & REPAIRS							
009	OPERATION OF PLANT	28,599						
010	LAUNDRY & LINEN SERVI	1,378	100					
011	HOUSEKEEPING	592		26,629				
012	DIETARY	2,102		2,102	100			
014	CAFETERIA	327		327		214,092		
017	NURSING ADMINISTRATIO	1,053		1,053		5,981	84,361	
020	MEDICAL RECORDS & LIB	534		534		13,491		26,745,665
020	NONPHYSICIAN ANESTHET							
025	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	7,850	100	7,850	100	63,291	63,291	3,173,042
037	ANCILLARY SRVC COST C							
040	OPERATING ROOM	1,293		1,293		9,393	9,393	1,660,757
041	ANESTHESIOLOGY	250		250				750,356
044	RADIOLOGY-DIAGNOSTIC	2,063		2,063		16,846		6,660,579
049	LABORATORY	1,060		1,060		24,596		4,750,637
050	RESPIRATORY THERAPY	1,989		1,989		15,063		2,411,192
055	PHYSICAL THERAPY	120		120		8,616		835,768
056	MEDICAL SUPPLIES CHAR	354		354		5,693		403,901
059	DRUGS CHARGED TO PATI	1,219		1,219		7,186		2,487,543
060	OTHER ANCILLARY SERVI	1,100		1,100		4,373		178,001
060	OUTPAT SERVICE COST C							
061	CLINIC	1,589		1,589		15,043		1,616,596
062	EMERGENCY	396		396		11,677	11,677	1,817,293
063	OBSERVATION BEDS (NON							
063	FAMILY PRACTICE							
063	50 RURAL HEALTH CLINIC	3,330		3,330				
095	SPEC PURPOSE COST CEN							
095	SUBTOTALS	28,599	100	26,629	100	201,249	84,361	26,745,665
098	NONREIMBURS COST CENT							
098	PHYSICIANS' PRIVATE O					10,763		
101	01 MARKETING					2,080		
102	CROSS FOOT ADJUSTMENT							
103	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	469,421	164,562	332,720	477,260	134,320	297,738	362,650
104	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER		1.645.620000		4.772.600000		3.529332	
105	(WRKSHT B, PT I)	16.413896		12.494649		.627394		.013559
105	COST TO BE ALLOCATED							
106	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
107	(WRKSHT B, PT II)	49,854	31,055	18,002	52,349	9,212	27,459	18,022
107	COST TO BE ALLOCATED							
108	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER	1.743208	310.550000	.676030	523.490000	.043028	.325494	.000674
108	(WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

COST CENTER	DESCRIPTION	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)
		20
	GENERAL SERVICE COST	
003	NEW CAP REL COSTS-BLD	
004	NEW CAP REL COSTS-MVB	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENE	
007	MAINTENANCE & REPAIRS	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVI	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATIO	
017	MEDICAL RECORDS & LIB	
020	NONPHYSICIAN ANESTHET	100
	INPAT ROUTINE SRVC CN	
025	ADULTS & PEDIATRICS	
	ANCILLARY SRVC COST C	
037	OPERATING ROOM	
040	ANESTHESIOLOGY	100
041	RADIOLOGY-DIAGNOSTIC	
044	LABORATORY	
049	RESPIRATORY THERAPY	
050	PHYSICAL THERAPY	
055	MEDICAL SUPPLIES CHAR	
056	DRUGS CHARGED TO PATI	
059	OTHER ANCILLARY SERVI	
	OUTPAT SERVICE COST C	
060	CLINIC	
061	EMERGENCY	
062	OBSERVATION BEDS (NON	
063	FAMILY PRACTICE	
063 50	RURAL HEALTH CLINIC	
	SPEC PURPOSE COST CEN	
095	SUBTOTALS	100
	NONREIMBURS COST CENT	
098	PHYSICIANS' PRIVATE O	
098 01	MARKETING	
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	COST TO BE ALLOCATED	
	(PER WRKSHT B, PART	
104	UNIT COST MULTIPLIER	
	(WRKSHT B, PT I)	
105	COST TO BE ALLOCATED	
	(PER WRKSHT B, PART	
106	UNIT COST MULTIPLIER	
	(WRKSHT B, PT II)	
107	COST TO BE ALLOCATED	
	(PER WRKSHT B, PART	
108	UNIT COST MULTIPLIER	
	(WRKSHT B, PT III)	

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,551,313		3,551,313		
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	589,253		589,253		
40	ANESTHESIOLOGY	48,784		48,784		
41	RADIOLOGY-DIAGNOSTIC	1,665,587		1,665,587		
44	LABORATORY	1,388,450		1,388,450		
49	RESPIRATORY THERAPY	755,042		755,042		
50	PHYSICAL THERAPY	433,738		433,738		
55	MEDICAL SUPPLIES CHARGED	434,141		434,141		
56	DRUGS CHARGED TO PATIENTS	1,059,334		1,059,334		
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS	778,056		778,056		
60	CLINIC	820,968		820,968		
61	EMERGENCY	1,213,591		1,213,591		
62	OBSERVATION BEDS (NON-DIS	661,679		661,679		
63	FAMILY PRACTICE					
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	754,992		754,992		
101	SUBTOTAL	14,154,928		14,154,928		
102	LESS OBSERVATION BEDS	661,679		661,679		
103	TOTAL	13,493,249		13,493,249		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET C
 I I TO 3/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,529,864		2,529,864			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	122,238	1,538,519	1,660,757	.354810	.354810	
40	ANESTHESIOLOGY	10,346	211,626	221,972	.219775	.219775	
41	RADIOLOGY-DIAGNOSTIC	646,481	6,014,098	6,660,579	.250066	.250066	
44	LABORATORY	615,022	4,135,615	4,750,637	.292266	.292266	
49	RESPIRATORY THERAPY	530,575	933,781	1,464,356	.515614	.515614	
50	PHYSICAL THERAPY	83,443	752,325	835,768	.518969	.518969	
55	MEDICAL SUPPLIES CHARGED	828,507	522,230	1,350,737	.321410	.321410	
56	DRUGS CHARGED TO PATIENTS	1,543,138	944,405	2,487,543	.425856	.425856	
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS		178,001	178,001	4.371077	4.371077	
60	CLINIC		1,616,596	1,616,596	.507837	.507837	
61	EMERGENCY	57,944	1,759,349	1,817,293	.667802	.667802	
62	OBSERVATION BEDS (NON-DIS	60,277	582,901	643,178	1.028765	1.028765	
63	FAMILY PRACTICE						
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS		476,257	476,257	1.585262	1.585262	
101	SUBTOTAL	7,027,835	19,665,703	26,693,538			
102	LESS OBSERVATION BEDS						
103	TOTAL	7,027,835	19,665,703	26,693,538			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
I 14-1324 I FROM 4/ 1/2009 I WORKSHEET C
I I TO 3/31/2010 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,551,313		3,551,313		
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	589,253		589,253		
40	ANESTHESIOLOGY	48,784		48,784		
41	RADIOLOGY-DIAGNOSTIC	1,665,587		1,665,587		
44	LABORATORY	1,388,450		1,388,450		
49	RESPIRATORY THERAPY	755,042		755,042		
50	PHYSICAL THERAPY	433,738		433,738		
55	MEDICAL SUPPLIES CHARGED	434,141		434,141		
56	DRUGS CHARGED TO PATIENTS	1,059,334		1,059,334		
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS	778,056		778,056		
60	CLINIC	820,968		820,968		
61	EMERGENCY	1,213,591		1,213,591		
62	OBSERVATION BEDS (NON-DIS	661,679		661,679		
63	FAMILY PRACTICE					
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	754,992		754,992		
101	SUBTOTAL	14,154,928		14,154,928		
102	LESS OBSERVATION BEDS	661,679		661,679		
103	TOTAL	13,493,249		13,493,249		

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,529,864		2,529,864			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	122,238	1,538,519	1,660,757	.354810	.354810	
40	ANESTHESIOLOGY	10,346	211,626	221,972	.219775	.219775	
41	RADIOLOGY-DIAGNOSTIC	646,481	6,014,098	6,660,579	.250066	.250066	
44	LABORATORY	615,022	4,135,615	4,750,637	.292266	.292266	
49	RESPIRATORY THERAPY	530,575	933,781	1,464,356	.515614	.515614	
50	PHYSICAL THERAPY	83,443	752,325	835,768	.518969	.518969	
55	MEDICAL SUPPLIES CHARGED	828,507	522,230	1,350,737	.321410	.321410	
56	DRUGS CHARGED TO PATIENTS	1,543,138	944,405	2,487,543	.425856	.425856	
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS		178,001	178,001	4.371077	4.371077	
60	CLINIC		1,616,596	1,616,596	.507837	.507837	
61	EMERGENCY	57,944	1,759,349	1,817,293	.667802	.667802	
62	OBSERVATION BEDS (NON-DIS	60,277	582,901	643,178	1.028765	1.028765	
63	FAMILY PRACTICE						
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS		476,257	476,257	1.585262	1.585262	
101	SUBTOTAL	7,027,835	19,665,703	26,693,538			
102	LESS OBSERVATION BEDS						
103	TOTAL	7,027,835	19,665,703	26,693,538			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	589,253	40,945	548,308			589,253
40	ANESTHESIOLOGY	48,784	6,411	42,373			48,784
41	RADIOLOGY-DIAGNOSTIC	1,665,587	76,081	1,589,506			1,665,587
44	LABORATORY	1,388,450	49,650	1,338,800			1,388,450
49	RESPIRATORY THERAPY	755,042	56,454	698,588			755,042
50	PHYSICAL THERAPY	433,738	10,852	422,886			433,738
55	MEDICAL SUPPLIES CHARGED	434,141	15,462	418,679			434,141
56	DRUGS CHARGED TO PATIENTS	1,059,334	45,580	1,013,754			1,059,334
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS	778,056	37,006	741,050			778,056
60	CLINIC	820,968	48,935	772,033			820,968
61	EMERGENCY	1,213,591	34,070	1,179,521			1,213,591
62	OBSERVATION BEDS (NON-DIS	661,679		661,679			661,679
63	FAMILY PRACTICE						
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	754,992	82,913	672,079			754,992
101	SUBTOTAL	10,603,615	504,359	10,099,256			10,603,615
102	LESS OBSERVATION BEDS	661,679		661,679			661,679
103	TOTAL	9,941,936	504,359	9,437,577			9,941,936

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	1,660,757	.354810	.354810
40	ANESTHESIOLOGY	221,972	.219775	.219775
41	RADIOLOGY-DIAGNOSTIC	6,660,579	.250066	.250066
44	LABORATORY	4,750,637	.292266	.292266
49	RESPIRATORY THERAPY	1,464,356	.515614	.515614
50	PHYSICAL THERAPY	835,768	.518969	.518969
55	MEDICAL SUPPLIES CHARGED	1,350,737	.321410	.321410
56	DRUGS CHARGED TO PATIENTS	2,487,543	.425856	.425856
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS	178,001	4.371077	4.371077
60	CLINIC	1,616,596	.507837	.507837
61	EMERGENCY	1,817,293	.667802	.667802
62	OBSERVATION BEDS (NON-DIS	643,178	1.028765	1.028765
63	FAMILY PRACTICE			
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	476,257	1.585262	1.585262
101	SUBTOTAL	24,163,674		
102	LESS OBSERVATION BEDS	643,178		
103	TOTAL	23,520,496		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	589,253	40,945	548,308			589,253
40	ANESTHESIOLOGY	48,784	6,411	42,373			48,784
41	RADIOLOGY-DIAGNOSTIC	1,665,587	76,081	1,589,506			1,665,587
44	LABORATORY	1,388,450	49,650	1,338,800			1,388,450
49	RESPIRATORY THERAPY	755,042	56,454	698,588			755,042
50	PHYSICAL THERAPY	433,738	10,852	422,886			433,738
55	MEDICAL SUPPLIES CHARGED	434,141	15,462	418,679			434,141
56	DRUGS CHARGED TO PATIENTS	1,059,334	45,580	1,013,754			1,059,334
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS	778,056	37,006	741,050			778,056
60	CLINIC	820,968	48,935	772,033			820,968
61	EMERGENCY	1,213,591	34,070	1,179,521			1,213,591
62	OBSERVATION BEDS (NON-DIS	661,679		661,679			661,679
63	FAMILY PRACTICE						
63 50	RURAL HEALTH CLINIC	754,992	82,913	672,079			754,992
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	10,603,615	504,359	10,099,256			10,603,615
102	LESS OBSERVATION BEDS	661,679		661,679			661,679
103	TOTAL	9,941,936	504,359	9,437,577			9,941,936

Health Financial Systems MCRIF32 FOR FERRELL HOSPITAL
 CALCULATION OF OUTPATIENT SERVICE COST TO
 CHARGE RATIOS NET OF REDUCTIONS
 SPECIAL TITLE XIX WORKSHEET

**NOT A CMS WORKSHEET ** (09/2000)
 I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET C
 I I TO 3/31/2010 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	1,660,757	.354810	.354810
40	ANESTHESIOLOGY	221,972	.219775	.219775
41	RADIOLOGY-DIAGNOSTIC	6,660,579	.250066	.250066
44	LABORATORY	4,750,637	.292266	.292266
49	RESPIRATORY THERAPY	1,464,356	.515614	.515614
50	PHYSICAL THERAPY	835,768	.518969	.518969
55	MEDICAL SUPPLIES CHARGED	1,350,737	.321410	.321410
56	DRUGS CHARGED TO PATIENTS	2,487,543	.425856	.425856
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS	178,001	4.371077	4.371077
60	CLINIC	1,616,596	.507837	.507837
61	EMERGENCY	1,817,293	.667802	.667802
62	OBSERVATION BEDS (NON-DIS	643,178	1.028765	1.028765
63	FAMILY PRACTICE			
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	476,257	1.585262	1.585262
101	SUBTOTAL	24,163,674		
102	LESS OBSERVATION BEDS	643,178		
103	TOTAL	23,520,496		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY CDSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET C
 I I TO 3/31/2010 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	483,633	1,081,224			
40	ANESTHESIOLOGY	45,973	142,754			
41	RADIOLOGY-DIAGNOSTIC	1,249,931	4,919,897			
44	LABORATORY	1,130,267	3,478,055			
49	RESPIRATORY THERAPY	648,674	1,162,187			
50	PHYSICAL THERAPY	330,512	513,301			
55	MEDICAL SUPPLIES CHARGED	304,210	880,830			
56	DRUGS CHARGED TO PATIENTS	646,153	1,789,682			
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS					
60	CLINIC	655,792	994,714			
61	EMERGENCY	889,726	1,143,003			
62	DBSERVATION BEDS (NON-DIS	577,418	534,497			
63	FAMILY PRACTICE					
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS					
101	TOTAL	6,962,289	16,640,144			

COMPUTATION OF OUTPATIENT COST PER VISIT -
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
I 14-1324 I FROM 4/ 1/2009 I WORKSHEET C
I I TO 3/31/2010 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM	483,633		483,633	1,081,224			
40	ANESTHESIOLOGY	45,973		45,973	142,754			
41	RADIOLOGY-DIAGNOSTIC	1,249,931		1,249,931	4,919,897			
44	LABORATORY	1,130,267		1,130,267	3,478,055			
49	RESPIRATORY THERAPY	648,674		648,674	1,162,187			
50	PHYSICAL THERAPY	330,512		330,512	513,301			
55	MEDICAL SUPPLIES CHARGED	304,210		304,210	880,830			
56	DRUGS CHARGED TO PATIENTS	646,153		646,153	1,789,682			
59	OTHER ANCILLARY SERVICE C OUTPAT SERVICE COST CNTRS							
60	CLINIC	655,792		655,792	994,714			
61	EMERGENCY	889,726	321,060	1,210,786	1,143,003			
62	OBSERVATION BEDS (NON-DIS	577,418		577,418	534,497			
63	FAMILY PRACTICE							
63	50 RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	6,962,289	321,060	7,283,349	16,640,144			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET D
 I COMPONENT NO: I TO 3/31/2010 I PART V
 I 14-1324 I I

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					
37 OPERATING ROOM	.354810		.354810		
40 ANESTHESIOLOGY	.219775		.219775		
41 RADIOLOGY-DIAGNOSTIC	.250066		.250066		
44 LABORATORY	.292266		.292266		
49 RESPIRATORY THERAPY	.515614		.515614		
50 PHYSICAL THERAPY	.518969		.518969		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.321410		.321410		
56 DRUGS CHARGED TO PATIENTS	.425856		.425856		
59 OTHER ANCILLARY SERVICE COST CENTERS	4.371077		4.371077		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	.507837		.507837		
61 EMERGENCY	.667802		.667802		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.028765		1.028765		
63 FAMILY PRACTICE					
63 50 RURAL HEALTH CLINIC					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET D
 I COMPONENT NO: I TO 3/31/2010 I PART V
 I 14-1324 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		624,475			
40 ANESTHESIOLOGY		104,752			
41 RADIOLOGY-DIAGNOSTIC		1,882,196			
44 LABORATORY		1,838,933			
49 RESPIRATORY THERAPY		621,288			
50 PHYSICAL THERAPY		198,866			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		212,495			
56 DRUGS CHARGED TO PATIENTS		532,922			
59 OTHER ANCILLARY SERVICE COST CENTERS		52,407			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		1,616,596			
61 EMERGENCY		307,529			
62 OBSERVATION BEDS (NON-DISTINCT PART)		288,155			
63 FAMILY PRACTICE					
63 50 RURAL HEALTH CLINIC					
101 SUBTOTAL		8,280,614			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		8,280,614			

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET D
 I COMPONENT NO: I TO 3/31/2010 I PART V
 I 14-1324 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	221,570		
40 ANESTHESIOLOGY	23,022		
41 RADIOLOGY-DIAGNOSTIC	470,673		
44 LABORATORY	537,458		
49 RESPIRATORY THERAPY	320,345		
50 PHYSICAL THERAPY	103,205		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	68,298		
56 DRUGS CHARGED TO PATIENTS	226,948		
59 OTHER ANCILLARY SERVICE COST CENTERS	229,075		
OUTPAT SERVICE COST CNTRS			
60 CLINIC	820,967		
61 EMERGENCY	205,368		
62 OBSERVATION BEDS (NON-DISTINCT PART)	296,444		
63 FAMILY PRACTICE			
63 50 RURAL HEALTH CLINIC			
101 SUBDTAL	3,523,373		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-			
PROGRAM ONLY CHARGES			
104 NET CHARGES	3,523,373		

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 9/ 1/2010
I	14-1324	I	FROM 4/ 1/2009	I	WORKSHEET D
I	COMPONENT NO:	I	TO 3/31/2010	I	PART VI
I	14-1324	I		I	

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1
2	PROGRAM VACCINE CHARGES	.425856
3	PROGRAM COSTS	195
		83

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET D
 I COMPONENT NO: I TO 3/31/2010 I PART V
 I 14-1324 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.354810				457,096
40 ANESTHESIOLOGY	.219775				
41 RADIOLOGY-DIAGNOSTIC	.250066				1,788,294
44 LABORATORY	.292266				769,982
49 RESPIRATORY THERAPY	.515614				237,303
50 PHYSICAL THERAPY	.518969				137,071
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.321410				99,347
56 DRUGS CHARGED TO PATIENTS	.425856				217,393
59 OTHER ANCILLARY SERVICE COST CENTERS	4.371077				
OUTPAT SERVICE COST CNTRS					
60 CLINIC	.507837				
61 EMERGENCY	.667802				691,378
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.028765				
63 FAMILY PRACTICE					
63 50 RURAL HEALTH CLINIC	1.585262				
101 SUBTOTAL					4,397,864
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					4,397,864

(A) WORKSHEET A LINE NUMBERS

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

TITLE XIX - O/P

HOSPITAL

Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
(A) ANCILLARY SRVC COST CNTRS	5.01	5.02	5.03	6	7
37 OPERATING ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
59 OTHER ANCILLARY SERVICE COST CENTERS					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
63 FAMILY PRACTICE					
63 50 RURAL HEALTH CLINIC					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET D
 I COMPONENT NO: I TO 3/31/2010 I PART V
 I 14-1324 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
	8	9	9.01	9.02	9.03
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		162,182			
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		447,192			
44 LABORATORY		225,040			
49 RESPIRATORY THERAPY		122,357			
50 PHYSICAL THERAPY		71,136			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		31,931			
56 DRUGS CHARGED TO PATIENTS		92,578			
59 OTHER ANCILLARY SERVICE COST CENTERS					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY		461,704			
62 OBSERVATION BEDS (NON-DISTINCT PART)					
63 FAMILY PRACTICE					
63 50 RURAL HEALTH CLINIC					
101 SUBTOTAL		1,614,120			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		1,614,120			

(A) WORKSHEET A LINE NUMBERS

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

COMPUTATION OF INPATIENT OPERATING COST

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,918
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,330
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,330
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	588
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,790
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	588
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	153.97
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,551,313
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	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	532,969
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,018,344

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,173,042
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,173,042
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.951246
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	952.87
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,018,344

COMPUTATION OF INPATIENT OPERATING COST

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 906.41
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,622,474
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,622,474

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					932,085 2,554,559

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) 532,969
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST
 REPORTING PERIOD (SEE INSTRUCTIONS)
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 532,969
 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

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET D-1
 I COMPONENT NO: I TO 3/31/2010 I PART III
 I 14-1324 I I

COMPUTATION OF INPATIENT OPERATING COST

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	730
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	906.41
85	OBSERVATION BED COST	661,679

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET D-4
 I COMPONENT NO: I TO 3/31/2010 I
 I 14-1324 I

TITLE XVIII, PART A HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,508,957	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.354810	70,655	25,069
40	ANESTHESIOLOGY	.219775	10,346	2,274
41	RADIOLOGY-DIAGNOSTIC	.250066	311,273	77,839
44	LABORATORY	.292266	381,519	111,505
49	RESPIRATORY THERAPY	.515614	321,712	165,879
50	PHYSICAL THERAPY	.518969	31,310	16,249
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.321410	512,749	164,803
56	DRUGS CHARGED TO PATIENTS	.425856	865,239	368,467
59	OTHER ANCILLARY SERVICE COST CENTERS OUTPAT SERVICE COST CNTRS	4.371077		
60	CLINIC	.507837		
61	EMERGENCY	.667802		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.028765		
63	FAMILY PRACTICE			
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS			
101	TOTAL		2,504,803	932,085
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		2,504,803	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET D-4
 I COMPONENT NO: I TO 3/31/2010 I
 I 14-2324 I I

TITLE XVIII, PART A SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.354810	1,754	622
40	ANESTHESIOLOGY	.219775		
41	RADIOLOGY-DIAGNOSTIC	.250066	34,657	8,667
44	LABORATORY	.292266	46,683	13,644
49	RESPIRATORY THERAPY	.515614	92,943	47,923
50	PHYSICAL THERAPY	.518969	41,914	21,752
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.321410	146,530	47,096
56	DRUGS CHARGED TO PATIENTS	.425856	214,895	91,514
59	OTHER ANCILLARY SERVICE COST CENTERS OUTPAT SERVICE COST CNTRS	4.371077		
60	CLINIC	.507837		
61	EMERGENCY	.667802		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.028765		
63	FAMILY PRACTICE			
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS			
101	TOTAL		579,376	231,218
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		579,376	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET D-4
 I COMPONENT NO: I TO 3/31/2010 I
 I 14-1324 I I

TITLE XIX HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		514,924	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.354810	25,035	8,883
40	ANESTHESIOLOGY	.219775		
41	RADIOLOGY-DIAGNOSTIC	.250066	116,055	29,021
44	LABORATORY	.292266	84,239	24,620
49	RESPIRATORY THERAPY	.515614	113,838	58,696
50	PHYSICAL THERAPY	.518969	2,166	1,124
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.321410	4,259	1,369
56	DRUGS CHARGED TO PATIENTS	.425856	220,618	93,951
59	OTHER ANCILLARY SERVICE COST CENTERS OUTPAT SERVICE COST CNTRS	4.371077		
60	CLINIC	.507837		
61	EMERGENCY	.667802	23,357	15,598
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.028765		
63	FAMILY PRACTICE			
63 50	RURAL HEALTH CLINIC	1.585262		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		589,567	233,262
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		589,567	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 3,523,456
 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) 3,523,456

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) 3,558,691
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 65,983
 18.01 CAH ACTUAL BILLED COINSURANCE 1,316,926
 LINE 17.01 (SEE INSTRUCTIONS)
 19 SUBTOTAL (SEE INSTRUCTIONS) 2,175,782
 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 2,175,782
 24 PRIMARY PAYER PAYMENTS 841
 25 SUBTOTAL 2,174,941
 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)
 26 COMPOSITE RATE ESRD
 27 BAD DEBTS (SEE INSTRUCTIONS) 531,673
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 531,673
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES
 28 SUBTOTAL 2,706,614
 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 2,706,614
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
 34 INTERIM PAYMENTS 2,765,033
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
 35 BALANCE DUE PROVIDER/PROGRAM -58,419
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

TO BE COMPLETED BY CONTRACTOR

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				
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.		2,578,216		2,427,033
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)		87,275		338,000
ADJUSTMENTS TO PROVIDER .01	6/12/2009	13,289		
ADJUSTMENTS TO PROVIDER .02	9/18/2009	148,951		
ADJUSTMENTS TO PROVIDER .03	3/26/2010	36,032		
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	10/16/2009	12,977		
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		185,295		NONE
4 TOTAL INTERIM PAYMENTS		2,850,786		2,765,033
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02		483,829		58,419
7 TOTAL MEDICARE PROGRAM LIABILITY		2,366,957		2,706,614

NAME OF INTERMEDIARY:

INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET E-1
 I COMPONENT NO: I TO 3/31/2010 I
 I 14-2324 I I

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		735,103		
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 REVISIDN 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	10/16/2009	29,137	
ADJUSTMENTS TO PROVIDER	.02	9/18/2009	4,257	
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		33,394	NONE
4 TOTAL INTERIM PAYMENTS			768,497	
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
SUBTOTAL	.99		NONE	NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER	.01			
SETTLEMENT TO PROGRAM	.02		5,079	
7 TOTAL MEDICARE PROGRAM LIABILITY			763,418	

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

IN LIEU OF FORM CMS-2552-96-E-2 (05/2004)
 I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I
 I COMPONENT NO: I TO 3/31/2010 I WORKSHEET E-2
 I 14-2324 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	538,299	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	233,530	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	588	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	771,829	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	771,829	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	771,829	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	8,411	
14	80% OF PART B COSTS		
15	SUBTOTAL	763,418	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	763,418	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	768,497	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-5,079	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET E-3
 I COMPONENT NO: I TO 3/31/2010 I PART II
 I 14-1324 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,554,559
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,554,559
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,580,105

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	2,580,105
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	331,757
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,248,348
23	COINSURANCE	3,511
24	SUBTOTAL	2,244,837
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	122,120
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	122,120
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	2,366,957
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	2,366,957
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,850,786
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-483,829
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I
 I I TO 3/31/2010 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	485,682			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	4,360,448			
5 OTHER RECEIVABLES	489,918			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,537,686			
7 INVENTORY	228,689			
8 PREPAID EXPENSES	136,196			
9 OTHER CURRENT ASSETS	146,487			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	3,309,734			
FIXED ASSETS				
12 LAND				
12.01 LAND IMPROVEMENTS				
13 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS	5,103,498			
14.01 LESS ACCUMULATED DEPRECIATION	-2,082,033			
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT				
18.01 LESS ACCUMULATED DEPRECIATION				
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	3,021,465			
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS	213,434			
25 OTHER ASSETS	25,115			
26 TOTAL OTHER ASSETS	238,549			
27 TOTAL ASSETS	6,569,748			

BALANCE SHEET

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,058,143			
29 SALARIES, WAGES & FEES PAYABLE	722,177			
30 PAYROLL TAXES PAYABLE	19,139			
31 NOTES AND LOANS PAYABLE (SHORT TERM)	512,567			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	339,292			
35 OTHER CURRENT LIABILITIES				
36 TOTAL CURRENT LIABILITIES	2,651,318			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE	4,145,313			
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	4,145,313			
43 TOTAL LIABILITIES	6,796,631			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	-226,883			
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	-226,883			
52 TOTAL LIABILITIES AND FUND BALANCES	6,569,748			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		-516,344		
2 NET INCOME (LOSS)		289,472		
3 TOTAL		-226,872		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		-226,872		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM	10			
14				
15				
16				
17				
18 TOTAL DEDUCTIONS		10		
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		-226,882		

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET G-2
 I I TO 3/31/2010 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	3,173,042		3,173,042
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	3,173,042		3,173,042
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,173,042		3,173,042
17 00 ANCILLARY SERVICES	4,427,349	18,967,273	23,394,622
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC			
24 00 PRO FEE	133,606	1,635,870	1,769,476
25 00 TOTAL PATIENT REVENUES	7,733,997	20,603,143	28,337,140

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		15,152,248	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 RESERVED A&G	1,184,711		
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS		1,184,711	
40 00 TOTAL OPERATING EXPENSES		13,967,537	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET G-3
 I I TO 3/31/2010 I

DESCRIPTION		
1	TOTAL PATIENT REVENUES	28,337,140
2	LESS: ALLOWANCES AND DISCOUNTS ON	14,941,001
3	NET PATIENT REVENUES	13,396,139
4	LESS: TOTAL OPERATING EXPENSES	13,967,537
5	NET INCOME FROM SERVICE TO PATIENT	-571,398
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER REVENUE	1,241,731
24.01	OTHER OP REV	803,850
24.02		
25	TOTAL OTHER INCOME	2,045,581
26	TOTAL	1,474,183
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	1,184,711
28		
29		
30	TOTAL OTHER EXPENSES	1,184,711
31	NET INCOME (OR LOSS) FOR THE PERIO	289,472

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

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2	154,241		154,241	
3	24,724		24,724	
4				
5				
6				
7				
8				
9				
10	178,965		178,965	
SUBTOTAL (SUM OF LINES 1-9)				
COSTS UNDER AGREEMENT				
11				
12				
13				
14				
SUBTOTAL (SUM OF LINES 11-13)				
OTHER HEALTH CARE COSTS				
15				
16		18,988	18,988	
17		495	495	
18				
19				
20				
21		19,483	19,483	
22	178,965	19,483	198,448	
SUBTOTAL (SUM OF LINES 15-20)				
TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)				
COSTS OTHER THAN RHC/FQHC SERVICES				
23				
24				
25				
26				
27				
28				
TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
FACILITY OVERHEAD				
29				
30				
31	121,508	39,422	160,930	-11,362
32	121,508	39,422	160,930	-11,362
TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)				
TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)				
	300,473	58,905	359,378	-11,362

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

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS			
1			
2	154,241		154,241
3	24,724		24,724
4			
5			
6			
7			
8			
9			
10	178,965		178,965
SUBTOTAL (SUM OF LINES 1-9)			
COSTS UNDER AGREEMENT			
11			
12			
13			
14			
SUBTOTAL (SUM OF LINES 11-13)			
OTHER HEALTH CARE COSTS			
15	18,988		18,988
16	495		495
17			
18			
19			
20			
21	19,483		19,483
22	198,448		198,448
SUBTOTAL (SUM OF LINES 15-20)			
TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)			
COSTS OTHER THAN RHC/FQHC SERVICES			
23			
24			
25			
26			
27			
28			
TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
FACILITY OVERHEAD			
29			
30	149,568		149,568
31	149,568		149,568
32	348,016		348,016
TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)			
TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)			

ALLOCATION OF OVERHEAD
 TO RHC/FQHC SERVICES

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
1 POSITIONS				
1 PHYSICIANS	1.00	4,537	4,200	4,200
2 PHYSICIAN ASSISTANTS	.50	987	2,100	1,050
3 NURSE PRACTITIONERS			2,100	
4 SUBTOTAL (SUM OF LINES 1-3)	1.50	5,524		5,250
5 VISITING NURSE				
6 CLINICAL PSYCHOLOGIST				
7 CLINICAL SOCIAL WORKER				
8 TOTAL FTES AND VISITS (SUM OF LINES 4-7)	1.50	5,524		
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)		198,448		
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)		198,448		
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)		149,568		
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)		406,976		
16 TOTAL OVERHEAD (SUM OF LINES 14 AND 15)		556,544		
17 ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18 SUBTRACT LINE 17 FROM LINE 16		556,544		
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)		556,544		
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)		754,992		

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

RHC 1

VISITS AND PRODUCTIVITY

GREATER OF
COL. 2 OR
COL. 4
5

	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	5,524
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	5,524
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
I 14-1324 I FROM 4/ 1/2009 I WORKSHEET M-3
I COMPONENT NO: I TO 3/31/2010 I
I 14-8507 I I

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	754,992
	(FROM WORKSHEET M-2, LINE 20)	
2	COST OF VACCINES AND THEIR ADMINISTRATION	
	(FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	754,992
	(LINE 1 MINUS LINE 2)	
4	TOTAL VISITS	5,524
	(FROM WORKSHEET M-2, COLUMN 5, LINE 8)	
5	PHYSICIANS VISITS UNDER AGREEMENT	
	(FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,524
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	136.67

CALCULATION OF LIMIT (1)

	PRIOR TO	ON OR AFTER
	JANUARY 1	JANUARY 1
	1	2

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	76.84	76.84
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	136.67	136.67

10	CALCULATION OF SETTLEMENT		
	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		866
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		118,356
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)*		118,356
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		118,356
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		94,685
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		94,685
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)		94,685
25	INTERIM PAYMENTS		43,300
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		51,385
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

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

IN LIEU OF FORM CMS-2552-96 M-5 (11/1998)
 I PROVIDER NO: I PERIOD: I PREPARED 9/ 1/2010
 I 14-1324 I FROM 4/ 1/2009 I WORKSHEET M-5
 I COMPONENT NO: I TO 3/31/2010 I
 I 14-8507 I I

RHC 1

DESCRIPTION	P A R T		B AMOUNT
	MM/DD/YYYY		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1		2 43,300
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	
SUBTOTAL		.99	NONE
4 TOTAL INTERIM PAYMENTS			43,300
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)			
SETTLEMENT TO PROVIDER		.01	51,385
SETTLEMENT TO PROGRAM		.02	
7 TOTAL MEDICARE PROGRAM LIABILITY			94,685

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.