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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1333	PERIOD FROM 3/ 1/2009 TO 2/28/2010	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS
			DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 6/16/2010 TIME 16:20

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
SARAH D CULBERTSON 14-1333
FOR THE COST REPORTING PERIOD BEGINNING 3/ 1/2009 AND ENDING 2/28/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

_____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX
			A	B	
		1	2	3	4
1	HOSPITAL	0	7,899	366,617	0
3	SWING BED - SNF	0	-165,520	0	0
9	RHC	0	0	-54,883	0
9 .01	RHC II	0	0	0	0
9 .02	RHC III	0	0	0	0
100	TOTAL	0	-157,621	311,734	0

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX
IDENTIFICATION DATA

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 238 SOUTH CONGRESS P.O. BOX:
1.01 CITY: RUSHVILLE STATE: IL ZIP CODE: 62681- COUNTY: SCHUYLER

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
0	1	2	2.01	3	4	5	6
02.00 HOSPITAL	SARAH D CULBERTSON	14-1333		5/ 1/2004	N	O	N
04.00 SWING BED - SNF	SDCMH SWING BED- SNF	14-Z333		5/ 1/2004	N	O	N
14.00 HOSPITAL-BASED RHC	BEARDSTOWN CLINIC 1	14-3483		10/ 1/2006	N	O	N
14.01 HOSPITAL-BASED RHC 2	COMMUNITY MEDICAL CLINIC	14-3484		10/ 1/2006	N	O	N
14.02 HOSPITAL-BASED RHC 3	BEARDSTOWN CLINIC 2	14-3480		4/ 5/2006	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 3/ 1/2009 TO: 2/28/2010

		1	2	
18	TYPE OF CONTROL	11		

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1		
20	SUBPROVIDER			

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.			
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.			
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).			
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2		99914
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)			
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).			/ /

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	N
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y 5/ 1/2004
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02	

		1	2	3	4
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	0	0.0000	0.0000	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0		

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

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

29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	Y
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	Y
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).	Y	
40.01	NAME:	FI/CONTRACTOR NAME	FI/CONTRACTOR #
40.02	STREET:	P.O. BOX:	
40.03	CITY:	STATE: ZIP CODE: -	
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y	
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y	
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y	
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N	
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	Y	01/21/2010
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?	N	
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?	N	
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?	N	
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).		

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

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

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		
	PREMIUMS:	29,243	
	PAID LOSSES:	0	
	AND/OR SELF INSURANCE:	0	
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

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

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

MULTICAMPUS

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

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

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). Y 4/27/2010

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

PROVIDER NO: 14-1333 | PERIOD: FROM 3/ 1/2009 TO 2/28/2010 | PREPARED 6/16/2010 | WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / TITLE V 3	O/P VISITS / TITLE XVIII 4	TRIPS / NOT LTCH N/A 4.01	TRIPS / TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	25	9,125	23,602.37		761		56
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					928		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	25	9,125	23,602.37		1,689		56
12	TOTAL	25	9,125	23,602.37		1,689		56
13	RPCH VISITS							
17	OTHER LONG TERM CARE	26	9,490					
24	RURAL HEALTH CLINIC					5,183		
25	TOTAL	51						
26	OBSERVATION BED DAYS							38
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS / TOTAL ALL PATS 6	TRIPS / TOTAL OBSERVATION BEDS ADMITTED 6.01	TRIPS / OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. FTES TOTAL 7	INTERNS & RES. FTES LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			1,048				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			928				
4	ADULTS & PED-SB NF			137				
5	TOTAL ADULTS AND PEDS			2,113				
12	TOTAL			2,113				
13	RPCH VISITS							
17	OTHER LONG TERM CARE			6,839				
24	RURAL HEALTH CLINIC			19,974				
25	TOTAL							
26	OBSERVATION BED DAYS		38	388	5	383		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS			14				
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	FULL TIME EQUIV NONPAID WORKERS 11	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	DISCHARGES TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					223	19	313
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		121.97			223	19	313
13	RPCH VISITS							
17	OTHER LONG TERM CARE		13.45					32
24	RURAL HEALTH CLINIC		23.22					
25	TOTAL		158.64					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

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

PROVIDER NO:	PERIOD:	PREPARED
14-1333	FROM 3/ 1/2009	6/16/2010
COMPONENT NO:	TO 2/28/2010	WORKSHEET S-8
14-3483		

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 238 S. CONGRESS

1.01 CITY: RUSHVILLE STATE: IL ZIP CODE: 62681 COUNTY: SCHUYLER

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

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

PHYSICIAN INFORMATION:

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

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

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

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14
	0														
12	CLINIC			800	1700	800	1700	800	1700	800	1700	800	1700		
12.01	BEARDSTOWN CLINIC I			900	1700	900	1700	900	1900	900	1700	900	1700		
12.02	BEARDSTOWN CLINIC II			900	1700	900	1700	900	1700	900	1700	900	1700		

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

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

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES. Y 3

15 PROVIDER NAME: COMMUNITY MEDICAL CLINIC PROVIDER NUMBER: 143484

15.01 PROVIDER NAME: BEARDSTOWN CLINIC I PROVIDER NUMBER: 143483

15.02 PROVIDER NAME: BEARDSTOWN CLINIC II PROVIDER NUMBER: 143480

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		173,045	173,045	12,264	185,309
3.01	0301	NEW CAP REL COSTS-RHCS BLDG/MME		45,376	45,376	817	46,193
3.02	0302	NEW CAP REL COSTS-MED ARTS BLDG/MME		39,033	39,033	1,298	40,331
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		469,637	469,637	11,053	480,690
5	0500	EMPLOYEE BENEFITS		1,729,314	1,729,314		1,729,314
6.04	0651	HOSPITAL ONLY ADMIN & GENERAL	442,961	224,980	667,941	11,774	679,715
6.05	0660	OTHER ADMINISTRATIVE AND GENERAL	813,110	1,044,052	1,857,162	-26,737	1,830,425
7	0700	MAINTENANCE & REPAIRS	174,286	69,174	243,460		243,460
8	0800	OPERATION OF PLANT	57,399	177,337	234,736		234,736
8.01	0801	PLANT & HSKPG - RHCS		36,154	36,154		36,154
10	1000	HOUSEKEEPING	262,136	43,338	305,474		305,474
11	1100	DIETARY	306,946	301,426	608,372		608,372
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	91,236	18,276	109,512	21,832	131,344
17	1700	MEDICAL RECORDS & LIBRARY	368,076	67,761	435,837		435,837
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	744,511	114,787	859,298	-20,316	838,982
36	3600	OTHER LONG TERM CARE	449,128	43,460	492,588		492,588
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	153,971	101,400	255,371	-26,199	229,172
40	4000	ANESTHESIOLOGY	133,309	103,669	236,978		236,978
41	4100	RADIOLOGY-DIAGNOSTIC	343,039	416,846	759,885	19,673	779,558
44	4400	LABORATORY	350,337	703,446	1,053,783	63,830	1,117,613
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		57,414	57,414		57,414
49	4900	RESPIRATORY THERAPY		157,667	157,667		157,667
50	5000	PHYSICAL THERAPY	475,304	75,787	551,091		551,091
53	5300	ELECTROCARDIOLOGY	77,267	197,832	275,099		275,099
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	5600	DRUGS CHARGED TO PATIENTS		744,183	744,183		744,183
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	63,949	806,781	870,730	22,034	892,764
61	6100	EMERGENCY	400,415	1,169,350	1,569,765	2,649	1,572,414
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC	1,236,763	746,130	1,982,893	-84,607	1,898,286
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE					
90	9000	OTHER CAPITAL RELATED COSTS					
95		SUBTOTALS	6,944,143	9,877,655	16,821,798	9,365	16,831,163
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES	263,119	39,113	302,232	-12,000	290,232
100	7950	CULBERTSON GARDENS	162,770	207,061	369,831	2,635	372,466
100.01	7951	MEDICAL ARTS BUILDING					
100.02	7952	FOUNDATION					
101		TOTAL	7,370,032	10,123,829	17,493,861	-0-	17,493,861

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 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		185,309
3.01	0301	NEW CAP REL COSTS-RHCS BLDG/MME		46,193
3.02	0302	NEW CAP REL COSTS-MED ARTS BLDG/MME		40,331
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		480,690
5	0500	EMPLOYEE BENEFITS	-263,903	1,465,411
6.04	0651	HOSPITAL ONLY ADMIN & GENERAL	-48,399	631,316
6.05	0660	OTHER ADMINISTRATIVE AND GENERAL	-97,956	1,732,469
7	0700	MAINTENANCE & REPAIRS		243,460
8	0800	OPERATION OF PLANT	-673	234,063
8.01	0801	PLANT & HSKPG - RHCS		36,154
10	1000	HOUSEKEEPING		305,474
11	1100	DIETARY	-98,396	509,976
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION		131,344
17	1700	MEDICAL RECORDS & LIBRARY	-9,963	425,874
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		838,982
36	3600	OTHER LONG TERM CARE		492,588
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		229,172
40	4000	ANESTHESIOLOGY		236,978
41	4100	RADIOLOGY-DIAGNOSTIC	-1,590	777,968
44	4400	LABORATORY		1,117,613
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		57,414
49	4900	RESPIRATORY THERAPY		157,667
50	5000	PHYSICAL THERAPY		551,091
53	5300	ELECTROCARDIOLOGY	-39,463	235,636
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		
56	5600	DRUGS CHARGED TO PATIENTS		744,183
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC	-341,183	551,581
61	6100	EMERGENCY	-373,615	1,198,799
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310	RURAL HEALTH CLINIC	-99,068	1,799,218
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-1,374,209	15,456,954
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800	PHYSICIANS' PRIVATE OFFICES		290,232
100	7950	CULBERTSON GARDENS	-35,435	337,031
100.01	7951	MEDICAL ARTS BUILDING		
100.02	7952	FOUNDATION		
101		TOTAL	-1,409,644	16,084,217

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 6/16/2010
I 14-1333 I FROM 3/ 1/2009 I NOT A CMS WORKSHEET
I I TO 2/28/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
3.01	NEW CAP REL COSTS-RHCS BLDG/MME	0301	NEW CAP REL COSTS-BLDG & FIXT
3.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0302	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6.04	HOSPITAL ONLY ADMIN & GENERAL	0651	CASHIERING/ACCOUNTS RECEIVABLE
6.05	OTHER ADMINISTRATIVE AND GENERAL	0660	OTHER ADMINISTRATIVE AND GENERAL
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
8.01	PLANT & HSKPG - RHCS	0801	OPERATION OF PLANT
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	CULBERTSON GARDENS	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	MEDICAL ARTS BUILDING	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	FOUNDATION	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS | PROVIDER NO: 141333 | PERIOD: FROM 3/ 1/2009 TO 2/28/2010 | PREPARED 6/16/2010 | WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION	CODE (1)	INCREASE COST CENTER	LINE NO	SALARY	OTHER
		1	2	3	4	5
1	PROPERTY INSURANCE	A	OTHER CAPITAL RELATED COSTS	90		25,432
2			CULBERTSON GARDENS	100		2,835
3	HEALTHLINK ADMIN FEES	B	HOSPITAL ONLY ADMIN & GENERAL	6.04		13,104
4			OTHER ADMINISTRATIVE AND GENERAL	6.05		200
5	UTILIZATION RVW & ONCOLOGY SALARIES	C	NURSING ADMINISTRATION	14	12,341	
6			CLINIC	60	10,256	
7	SALARY RECLASS	D	NURSING ADMINISTRATION	14	9,491	
8			ADULTS & PEDIATRICS	25	2,281	
9			CLINIC	60	11,778	
10			EMERGENCY	61	2,649	
11	RHC PHYSICIAN EXPENSE	F	RURAL HEALTH CLINIC	63.50	12,000	
12	RHC X-RAY EXPENSE	G	RADIOLOGY-DIAGNOSTIC	41	16,405	3,268
13			LABORATORY	44	53,228	10,602
36	TOTAL RECLASSIFICATIONS				130,429	55,441

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

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	DECREASE SALARY	DECREASE OTHER	A-7 REF
	1		6	7	8	9	10
1	PROPERTY INSURANCE	A	HOSPITAL ONLY ADMIN & GENERAL	6.04		1,330	
2			OTHER ADMINISTRATIVE AND GENERAL	6.05		26,937	
3	HEALTHLINK ADMIN FEES	B	RURAL HEALTH CLINIC	63.50		13,104	
4			CULBERTSON GARDENS	100		200	
5	UTILIZATION RVW & ONCOLOGY SALARIES	C	ADULTS & PEDIATRICS	25	22,597		
6							
7	SALARY RECLASS	D	OPERATING ROOM	37	26,199		
8							
9							
10							
11	RHC PHYSICIAN EXPENSE	F	PHYSICIANS' PRIVATE OFFICES	98	12,000		
12	RHC X-RAY EXPENSE	G	RURAL HEALTH CLINIC	63.50	69,633	13,870	
13							
36	TOTAL RECLASSIFICATIONS				130,429	55,441	

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

RECLASS CODE: A
EXPLANATION : PROPERTY INSURANCE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	OTHER CAPITAL RELATED COSTS	90	25,432	HOSPITAL ONLY ADMIN & GENERAL	6.04	1,330
2.00	CULBERTSON GARDENS	100	2,835	OTHER ADMINISTRATIVE AND GENER	6.05	26,937
TOTAL RECLASSIFICATIONS FOR CODE A			28,267			28,267

RECLASS CODE: B
EXPLANATION : HEALTHLINK ADMIN FEES

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	HOSPITAL ONLY ADMIN & GENERAL	6.04	13,104	RURAL HEALTH CLINIC	63.50	13,104
2.00	OTHER ADMINISTRATIVE AND GENER	6.05	200	CULBERTSON GARDENS	100	200
TOTAL RECLASSIFICATIONS FOR CODE B			13,304			13,304

RECLASS CODE: C
EXPLANATION : UTILIZATION RVW & ONCOLOGY SALARIES

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NURSING ADMINISTRATION	14	12,341	ADULTS & PEDIATRICS	25	22,597
2.00	CLINIC	60	10,256			0
TOTAL RECLASSIFICATIONS FOR CODE C			22,597			22,597

RECLASS CODE: D
EXPLANATION : SALARY RECLASS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NURSING ADMINISTRATION	14	9,491	OPERATING ROOM	37	26,199
2.00	ADULTS & PEDIATRICS	25	2,281			0
3.00	CLINIC	60	11,778			0
4.00	EMERGENCY	61	2,649			0
TOTAL RECLASSIFICATIONS FOR CODE D			26,199			26,199

RECLASS CODE: F
EXPLANATION : RHC PHYSICIAN EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RURAL HEALTH CLINIC	63.50	12,000	PHYSICIANS' PRIVATE OFFICES	98	12,000
TOTAL RECLASSIFICATIONS FOR CODE F			12,000			12,000

RECLASS CODE: G
EXPLANATION : RHC X-RAY EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RADIOLOGY-DIAGNOSTIC	41	19,673	RURAL HEALTH CLINIC	63.50	83,503
2.00	LABORATORY	44	63,830			0
TOTAL RECLASSIFICATIONS FOR CODE G			83,503			83,503

Health Financial Systems MCRIF32 FOR SARAH D CULBERTSON IN LIEU OF FORM CMS-2552-96(09/1996)
ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL I PROVIDER NO: I PERIOD: I PREPARED 6/16/2010
ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE I 14-1333 I FROM 3/ 1/2009 I WORKSHEET A-7
COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS I I TO 2/28/2010 I PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
			PURCHASES	DONATION	TOTAL			
		1	2	3	4	5	6	7
1	LAND	289,461					289,461	
2	LAND IMPROVEMENTS	755,494	41,575		41,575	78,029	719,040	
3	BUILDINGS & FIXTURE	7,180,998	159,313		159,313	174,797	7,165,514	
4	BUILDING IMPROVEMEN	146,647	175,043		175,043	114,258	207,432	
5	FIXED EQUIPMENT	162,966	58,180		58,180	92,128	129,018	
6	MOVABLE EQUIPMENT	5,003,890	1,324,308		1,324,308	1,464,059	4,864,139	
7	SUBTOTAL	13,539,456	1,758,419		1,758,419	1,923,271	13,374,604	
8	RECONCILING ITEMS							
9	TOTAL	13,539,456	1,758,419		1,758,419	1,923,271	13,374,604	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	4,971,676		4,971,676	.482210	12,264			12,264
3 01	NEW CAP REL COSTS-RH	331,265		331,265	.032130	817			817
3 02	NEW CAP REL COSTS-ME	526,264		526,264	.051043	1,298			1,298
4	NEW CAP REL COSTS-MV	4,480,980		4,480,980	.434617	11,053			11,053
5	TOTAL	10,310,185		10,310,185	1.000000	25,432			25,432

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	173,045			12,264			185,309
3 01	NEW CAP REL COSTS-RH	16,042	28,945		817		389	46,193
3 02	NEW CAP REL COSTS-ME	20,563	18,470		1,298			40,331
4	NEW CAP REL COSTS-MV	420,960	48,677		11,053			480,690
5	TOTAL	630,610	96,092		25,432		389	752,523

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	173,045						173,045
3 01	NEW CAP REL COSTS-RH	16,042	28,945				389	45,376
3 02	NEW CAP REL COSTS-ME	20,563	18,470					39,033
4	NEW CAP REL COSTS-MV	420,960	48,677					469,637
5	TOTAL	630,610	96,092				389	727,091

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO	WKST. A-7 REF.
		1	2	3	4	5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER	B	-1,162	HOSPITAL ONLY ADMIN & GEN	6.04	
6	TRADE, QUANTITY AND TIME DISCOUNTS	B	-2,963	OTHER ADMINISTRATIVE AND	6.05	
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES	A	-7,696	HOSPITAL ONLY ADMIN & GEN	6.04	
10	TELEVISION AND RADIO SERVICE	A	-673	OPERATION OF PLANT	8	
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-847,403			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS					
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-6,921	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES	B	-498	DIETARY	11	
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	INTEREST INCOME	B	-18,447	HOSPITAL ONLY ADMIN & GEN	6.04	
38	INTEREST INCOME	B	-35,435	CULBERTSON GARDENS	100	
39	RHC MISCELLANEOUS INCOME	B	-1,097	RURAL HEALTH CLINIC	63.50	
40	OPC RENT	B	-11,172	HOSPITAL ONLY ADMIN & GEN	6.04	
41	MISCELLANEOUS INCOME	B	-22,716	OTHER ADMINISTRATIVE AND	6.05	
42	RHC MISCELLANEOUS INCOME	B	-3,042	MEDICAL RECORDS & LIBRARY	17	
43	RHC MISCELLANEOUS INCOME	B	-417	OTHER ADMINISTRATIVE AND	6.05	
44	OTHER ADJUSTMENTS (SPECIFY)					
45	MARKETING SALARY EXPENSE	A	-44,141	OTHER ADMINISTRATIVE AND	6.05	
46	MARKETING BENEFITS EXPENSE	A	-10,357	EMPLOYEE BENEFITS	5	
47	MARKETING OTHER EXPENSE	A	-38,504	HOSPITAL ONLY ADMIN & GEN	6.04	
48	MARKETING OTHER EXPENSE	A	-10,154	OTHER ADMINISTRATIVE AND	6.05	
49	MARKETING OTHER EXPENSE	A	-6,419	RURAL HEALTH CLINIC	63.50	
49.01	LOBBYING PORTION OF DUES	A	-6,966	OTHER ADMINISTRATIVE AND	6.05	
49.02	HEALTHLINK ADMINISTRATIVE FEES	A	43,989	HOSPITAL ONLY ADMIN & GEN	6.04	
49.03	SELF INSURANCE OFFSET	A	-252,321	EMPLOYEE BENEFITS	5	
49.04	PART B PHYSICIAN BILLING SALARIES	A	-5,221	OTHER ADMINISTRATIVE AND	6.05	
49.05	PART B PHYSICIAN BILLING EMP BENEFIT	A	-1,225	EMPLOYEE BENEFITS	5	
49.06	LIFELINE	A	-15,407	HOSPITAL ONLY ADMIN & GEN	6.04	
49.07	CHARITABLE CONTRIBUTIONS	A	-12,378	OTHER ADMINISTRATIVE AND	6.05	
49.08	MEALS ON WHEELS	B	-97,898	DIETARY	11	
49.09	PHYSICIAN RECRUITMENT	A	7,000	OTHER ADMINISTRATIVE AND	6.05	
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,409,644			

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
1	1 2	3	4	5	6	
1	6 5 OTHER ADMINISTRATIVE AND	CONTRACT LABOR	31,961	31,961		
2						
3						
4						
5	TOTALS		31,961	31,961		

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	E	DAVID SNIFF, CEO	100.00	MIDWEST CONSULTANTS	0.00	MANAGEMENT COMPANY
2	C		0.00	SCHUYLER COUNTY HD CTR	0.00	PHYSICIAN PRACTICE
3	C		0.00	CULBERTSON FOUNDATION	0.00	FOUNDATION
4			0.00		0.00	
5			0.00		0.00	

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 14-1333 I
I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I
I PREPARED 6/16/2010 I
I WORKSHEET A-8-2 I
I GROUP 1 I

	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	41		RADIOLOGY	1,590	1,590					
2	41		NUCLEAR MEDICINE	12,000		12,000				
3	44		LABORATORY	15,600		15,600				
4	49		RESPIRATORY THERAPY	6,000		6,000				
5	53		EKG	39,463	39,463					
6	60		GI	180,000	180,000					
7	60		ONCOLOGY	140,000	140,000					
8	60		TELEMEDICINE	9,183	9,183					
9	61		EMERGENCY ROOM	1,112,657	373,615	739,042				
10	63	50	RURAL HEALTH CLINIC	91,552	91,552					
11	60		WOUND CARE	12,000	12,000					
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
101			TOTAL	1,620,045	847,403	772,642				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10		COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	41		RADIOLOGY							1,590
2	41		NUCLEAR MEDICINE							
3	44		LABORATORY							
4	49		RESPIRATORY THERAPY							
5	53		EKG							39,463
6	60		GI							180,000
7	60		ONCOLOGY							140,000
8	60		TELEMEDICINE							9,183
9	61		EMERGENCY ROOM							373,615
10	63	50	RURAL HEALTH CLINIC							91,552
11	60		WOUND CARE							12,000
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
101			TOTAL							847,403

I PROVIDER NO:	I PERIOD:	I PREPARED 6/16/2010
I 14-1333	I FROM 3/ 1/2009	I WORKSHEET A-8-4
I	I TO 2/28/2010	I PARTS I - VII

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

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	3
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	45
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	4
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	5.50
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	.55

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		34.25			
10	AHSEA (SEE INSTRUCTIONS)		71.90			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	35.95	35.95			
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	2,463
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	2,463
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	2,463

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	71.91
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	3,236
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	3,236

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

STANDARD TRAVEL ALLOWANCE

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	144
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	144
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	22
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	166

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	I PROVIDER NO: I 14-1333	I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010	I PREPARED 6/16/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	166
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	3,236
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	166
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	

61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	3,402
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	1,279
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	1,279
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	1,279
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	11
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	165
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	50
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	5.50
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	.55

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		388.00			
10	AHSEA (SEE INSTRUCTIONS)		68.14			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	34.07	34.07			
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	26,438
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	26,438
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	26,438

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	26,438

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

STANDARD TRAVEL ALLOWANCE

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	1,704
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	1,704
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	275
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	1,979

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	1,979
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	26,438
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	1,979
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	

OCCUPATIONAL THERAPY

61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	28,417
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	17,573
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	17,573
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	17,573
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET A-8-4 I PARTS I - VII

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	21
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	315
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	46
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	5.50
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	.55

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		316.50			
10	AHSEA (SEE INSTRUCTIONS)		65.48			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.74	32.74			
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	20,724
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	20,724
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	20,724

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	20,724

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

STANDARD TRAVEL ALLOWANCE

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	1,506
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	1,506
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	253
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	1,759

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998	I PROVIDER NO: I 14-1333	I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010	I PREPARED 6/16/2010 I WORKSHEET A-8-4 I PARTS I - VII

SPEECH PATHOLOGY

31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	1,759
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	20,724
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	1,759
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	

61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	22,483
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	13,882
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	13,882
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	13,882
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

Health Financial Systems MCRIF32 FOR SARAH D CULBERTSON IN LIEU OF FORM CMS-2552-96(7/2009)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 6/16/2010
I 14-1333 I FROM 3/ 1/2009 I NOT A CMS WORKSHEET
I I TO 2/28/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	ENTERED
3.01	NEW CAP REL COSTS-RHCS BLDG/MME	2	SQUARE	FEET	ENTERED
3.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	4	GROSS	SALARIES	ENTERED
6.04	HOSPITAL ONLY ADMIN & GENERAL	-5	ACCUM.	COST	ENTERED
6.05	OTHER ADMINISTRATIVE AND GENERAL	-22	ACCUM.	COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	1	SQUARE	FEET	ENTERED
8	OPERATION OF PLANT	1	SQUARE	FEET	ENTERED
8.01	PLANT & HSKPG - RHCS	2	SQUARE	FEET	ENTERED
10	HOUSEKEEPING	1	SQUARE	FEET	ENTERED
11	DIETARY	8	MEALS	SERVED	ENTERED
12	CAFETERIA	9	MEALS	SERVED	ENTERED
14	NURSING ADMINISTRATION	10	DIRECT	NRSING HRS	ENTERED
17	MEDICAL RECORDS & LIBRARY	11	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET B I PART I

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-RHCS BL	NEW CAP REL COSTS-MED ART	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL
			0	3	3.01	3.02	4	5	6a.00
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	185,309	185,309					
003	01	NEW CAP REL COSTS-RHCS BL	46,193		46,193				
003	02	NEW CAP REL COSTS-MED ART	40,331			40,331			
004		NEW CAP REL COSTS-MVBLE E	480,690				480,690		
005		EMPLOYEE BENEFITS	1,465,411					1,465,411	
006	04	HOSPITAL ONLY ADMIN & GEN	631,316	10,184			26,418	78,788	746,706
006	05	OTHER ADMINISTRATIVE AND	1,732,469	24,040			62,360	162,763	1,981,632
007		MAINTENANCE & REPAIRS	243,460	17,741			46,019	34,888	342,108
008		OPERATION OF PLANT	234,063					11,490	245,553
008	01	PLANT & HSKPG - RHCS	36,154						36,154
010		HOUSEKEEPING	305,474	6,391			16,579	52,473	380,917
011		DIETARY	509,976	9,075			23,541	61,443	604,035
012		CAFETERIA		3,101			8,043		11,144
014		NURSING ADMINISTRATION	131,344	394			1,021	22,633	155,392
017		MEDICAL RECORDS & LIBRARY	425,874	11,756			30,495	73,679	541,804
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	838,982	19,506			50,598	144,965	1,054,051
036		OTHER LONG TERM CARE	492,588	27,737			71,950	89,904	682,179
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	229,172	8,416			21,831	25,577	284,996
040		ANESTHESIOLOGY	236,978					26,685	263,663
041		RADIOLOGY-DIAGNOSTIC	777,968	10,444			27,090	71,951	887,453
044		LABORATORY	1,117,613	3,048			7,907	80,783	1,209,351
046		WHOLE BLOOD & PACKED RED	57,414	328			851		58,593
049		RESPIRATORY THERAPY	157,667	2,067			5,362		165,096
050		PHYSICAL THERAPY	551,091	9,597			24,895	95,144	680,727
053		ELECTROCARDIOLOGY	235,636					15,467	251,103
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS	744,183	2,005			5,200		751,388
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	551,581	11,585			30,052	17,212	610,430
061		EMERGENCY	1,198,799	7,563			19,618	80,683	1,306,663
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	1,799,218		46,193			236,034	2,081,445
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	15,456,954	184,978	46,193		479,830	1,382,562	15,332,583
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC	290,232			9,010		50,267	349,509
100		CULBERTSON GARDENS	337,031					32,582	369,613
100	01	MEDICAL ARTS BUILDING				31,321			31,321
100	02	FOUNDATION		331			860		1,191
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	16,084,217	185,309	46,193	40,331	480,690	1,465,411	16,084,217

		COST CENTER DESCRIPTION	HOSPITAL ONLY ADMIN & GEN	SUBTOTAL	OTHER ADMINISTRATIVE AND	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HSKPG - RHCS	HOUSEKEEPING
			6.04	6a.04	6.05	7	8	8.01	10
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
003	01	NEW CAP REL COSTS-RHCS BL							
003	02	NEW CAP REL COSTS-MED ART							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006	04	HOSPITAL ONLY ADMIN & GEN	746,706						
006	05	OTHER ADMINISTRATIVE AND		1,981,632	1,981,632				
007		MAINTENANCE & REPAIRS	20,267	362,375	50,919	413,294			
008		OPERATION OF PLANT	14,547	260,100	36,548		296,648		
008	01	PLANT & HSKPG - RHCS	2,142	38,296	5,381			43,677	
010		HOUSEKEEPING	22,566	403,483	56,696	19,810	14,219		494,208
011		DIETARY	35,784	639,819	89,905	28,129	20,190		35,329
012		CAFETERIA	660	11,804	1,659	9,610	6,898		12,070
014		NURSING ADMINISTRATION	9,206	164,598	23,129	1,220	876		1,533
017		MEDICAL RECORDS & LIBRARY	32,098	573,902	80,642	36,437	26,153		45,764
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	62,444	1,116,495	156,885	60,457	43,394		75,933
036		OTHER LONG TERM CARE	40,414	722,593	101,536	85,974	61,706		107,977
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	16,884	301,880	42,419	26,084	18,723		32,762
040		ANESTHESIOLOGY	15,620	279,283	39,244				
041		RADIOLOGY-DIAGNOSTIC	52,574	940,027	132,089	32,369	23,233		40,655
044		LABORATORY	71,644	1,280,995	180,000	9,447	6,781		11,866
046		WHOLE BLOOD & PACKED RED	3,471	62,064	8,721	1,017	730		1,277
049		RESPIRATORY THERAPY	9,781	174,877	24,573	6,407	4,599		8,047
050		PHYSICAL THERAPY	40,328	721,055	101,320	29,745	21,350		37,360
053		ELECTROCARDIOLOGY	14,876	265,979	37,374				
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS	44,514	795,902	111,837	6,213	4,460		7,804
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	36,163	646,593	90,857	35,908	25,774		45,100
061		EMERGENCY	77,409	1,384,072	194,484	23,440	16,825		29,441
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	123,314	2,204,759	309,797			43,677	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	746,706	15,332,583	1,876,015	412,267	295,911	43,677	492,918
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC		349,509	49,112				
100		CULBERTSON GARDENS		369,613	51,937				
100	01	MEDICAL ARTS BUILDING		31,321	4,401				
100	02	FOUNDATION		1,191	167	1,027	737		1,290
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	746,706	16,084,217	1,981,632	413,294	296,648	43,677	494,208

		COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
			11	12	14	17	25	26	27
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
003	01	NEW CAP REL COSTS-RHCS BL							
003	02	NEW CAP REL COSTS-MED ART							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006	04	HOSPITAL ONLY ADMIN & GEN							
006	05	OTHER ADMINISTRATIVE AND							
007		MAINTENANCE & REPAIRS							
008		OPERATION OF PLANT							
008	01	PLANT & HSKPG - RHCS							
010		HOUSEKEEPING							
011		DIETARY	813,372						
012		CAFETERIA	200,364	242,405					
014		NURSING ADMINISTRATION		3,432	194,788				
017		MEDICAL RECORDS & LIBRARY		27,757		790,655			
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	109,405	47,113	71,992	187,370	1,869,044		1,869,044
036		OTHER LONG TERM CARE	311,032	39,528	60,396	10,138	1,500,880		1,500,880
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM		5,991	9,163		437,022		437,022
040		ANESTHESIOLOGY		2,800			321,327		321,327
041		RADIOLOGY-DIAGNOSTIC		19,388		119,252	1,307,013		1,307,013
044		LABORATORY		22,398		39,840	1,551,327		1,551,327
046		WHOLE BLOOD & PACKED RED					73,809		73,809
049		RESPIRATORY THERAPY				8,359	226,862		226,862
050		PHYSICAL THERAPY		21,405		6,225	938,460		938,460
053		ELECTROCARDIOLOGY		4,576	7,011	30,146	345,086		345,086
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS					926,216		926,216
		OUTPAT SERVICE COST CNTRS							
060		CLINIC		5,539	8,466	99,154	957,391		957,391
061		EMERGENCY		24,716	37,760	116,762	1,827,500		1,827,500
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC				173,409	2,731,642		2,731,642
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	620,801	224,643	194,788	790,655	15,013,579		15,013,579
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC					398,621		398,621
100		CULBERTSON GARDENS	192,571	17,762			631,883		631,883
100	01	MEDICAL ARTS BUILDING					35,722		35,722
100	02	FOUNDATION					4,412		4,412
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	813,372	242,405	194,788	790,655	16,084,217		16,084,217

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET B I PART III

		COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-RHCS BL	NEW CAP REL COSTS-MED ART	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS
			0	3	3.01	3.02	4	4a	5
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
003	01	NEW CAP REL COSTS-RHCS BL							
003	02	NEW CAP REL COSTS-MED ART							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006	04	HOSPITAL ONLY ADMIN & GEN		10,184			26,418	36,602	
006	05	OTHER ADMINISTRATIVE AND		24,040			62,360	86,400	
007		MAINTENANCE & REPAIRS		17,741			46,019	63,760	
008		OPERATION OF PLANT							
008	01	PLANT & HSKPG - RHCS							
010		HOUSEKEEPING		6,391			16,579	22,970	
011		DIETARY		9,075			23,541	32,616	
012		CAFETERIA		3,101			8,043	11,144	
014		NURSING ADMINISTRATION		394			1,021	1,415	
017		MEDICAL RECORDS & LIBRARY		11,756			30,495	42,251	
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS		19,506			50,598	70,104	
036		OTHER LONG TERM CARE		27,737			71,950	99,687	
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM		8,416			21,831	30,247	
040		ANESTHESIOLOGY							
041		RADIOLOGY-DIAGNOSTIC		10,444			27,090	37,534	
044		LABORATORY		3,048			7,907	10,955	
046		WHOLE BLOOD & PACKED RED		328			851	1,179	
049		RESPIRATORY THERAPY		2,067			5,362	7,429	
050		PHYSICAL THERAPY		9,597			24,895	34,492	
053		ELECTROCARDIOLOGY							
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS		2,005			5,200	7,205	
		OUTPAT SERVICE COST CNTRS							
060		CLINIC		11,585			30,052	41,637	
061		EMERGENCY		7,563			19,618	27,181	
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC			46,193			46,193	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS		184,978	46,193		479,830	711,001	
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC				9,010		9,010	
100		CULBERTSON GARDENS							
100	01	MEDICAL ARTS BUILDING				31,321		31,321	
100	02	FOUNDATION		331			860	1,191	
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL		185,309	46,193	40,331	480,690	752,523	

		COST CENTER DESCRIPTION	HOSPITAL ADMIN & GEN	OTHER ADMINISTRATIVE AND	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HSKPG - RHCS	HOUSEKEEPING	DIETARY
			6.04	6.05	7	8	8.01	10	11
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
003	01	NEW CAP REL COSTS-RHCS BL							
003	02	NEW CAP REL COSTS-MED ART							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006	04	HOSPITAL ONLY ADMIN & GEN	36,602						
006	05	OTHER ADMINISTRATIVE AND		86,400					
007		MAINTENANCE & REPAIRS	993	2,220	66,973				
008		OPERATION OF PLANT	713	1,594		2,307			
008	01	PLANT & HSKPG - RHCS	105	235			340		
010		HOUSEKEEPING	1,106	2,472	3,210	111		29,869	
011		DIETARY	1,754	3,920	4,558	157		2,135	45,140
012		CAFETERIA	32	72	1,557	54		729	11,120
014		NURSING ADMINISTRATION	451	1,008	198	7		93	
017		MEDICAL RECORDS & LIBRARY	1,573	3,516	5,904	203		2,766	
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	3,061	6,841	9,797	337		4,589	6,072
036		OTHER LONG TERM CARE	1,981	4,427	13,933	478		6,527	17,261
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	828	1,850	4,227	146		1,980	
040		ANESTHESIOLOGY	766	1,711					
041		RADIOLOGY-DIAGNOSTIC	2,577	5,760	5,245	181		2,457	
044		LABORATORY	3,512	7,849	1,531	53		717	
046		WHOLE BLOOD & PACKED RED	170	380	165	6		77	
049		RESPIRATORY THERAPY	479	1,071	1,038	36		486	
050		PHYSICAL THERAPY	1,977	4,418	4,820	166		2,258	
053		ELECTROCARDIOLOGY	729	1,630					
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS	2,182	4,876	1,007	35		472	
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	1,773	3,962	5,819	200		2,726	
061		EMERGENCY	3,795	8,480	3,798	131		1,779	
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	6,045	13,503			340		
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	36,602	81,795	66,807	2,301	340	29,791	34,453
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC		2,141					
100		CULBERTSON GARDENS		2,265					10,687
100	01	MEDICAL ARTS BUILDING		192					
100	02	FOUNDATION		7	166	6		78	
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	36,602	86,400	66,973	2,307	340	29,869	45,140

		COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
			12	14	17	25	26	27
		GENERAL SERVICE COST CNTR						
003		NEW CAP REL COSTS-BLDG &						
003	01	NEW CAP REL COSTS-RHCS BL						
003	02	NEW CAP REL COSTS-MED ART						
004		NEW CAP REL COSTS-MVBLE E						
005		EMPLOYEE BENEFITS						
006	04	HOSPITAL ONLY ADMIN & GEN						
006	05	OTHER ADMINISTRATIVE AND						
007		MAINTENANCE & REPAIRS						
008		OPERATION OF PLANT						
008	01	PLANT & HSKPG - RHCS						
010		HOUSEKEEPING						
011		DIETARY						
012		CAFETERIA	24,708					
014		NURSING ADMINISTRATION	350	3,522				
017		MEDICAL RECORDS & LIBRARY	2,829		59,042			
		INPAT ROUTINE SRVC CNTRS						
025		ADULTS & PEDIATRICS	4,803	1,301	13,993	120,898		120,898
036		OTHER LONG TERM CARE	4,029	1,092	757	150,172		150,172
		ANCILLARY SRVC COST CNTRS						
037		OPERATING ROOM	611	166		40,055		40,055
040		ANESTHESIOLOGY	285			2,762		2,762
041		RADIOLOGY-DIAGNOSTIC	1,976		8,905	64,635		64,635
044		LABORATORY	2,283		2,975	29,875		29,875
046		WHOLE BLOOD & PACKED RED				1,977		1,977
049		RESPIRATORY THERAPY			624	11,163		11,163
050		PHYSICAL THERAPY	2,182		465	50,778		50,778
053		ELECTROCARDIOLOGY	466	127	2,251	5,203		5,203
055		MEDICAL SUPPLIES CHARGED						
056		DRUGS CHARGED TO PATIENTS				15,777		15,777
		OUTPAT SERVICE COST CNTRS						
060		CLINIC	565	153	7,404	64,239		64,239
061		EMERGENCY	2,519	683	8,719	57,085		57,085
062		OBSERVATION BEDS (NON-DIS						
063		OTHER OUTPATIENT SERVICE						
063	50	RURAL HEALTH CLINIC			12,949	79,030		79,030
		SPEC PURPOSE COST CENTERS						
095		SUBTOTALS	22,898	3,522	59,042	693,649		693,649
		NONREIMBURS COST CENTERS						
096		GIFT, FLOWER, COFFEE SHOP						
098		PHYSICIANS' PRIVATE OFFIC				11,151		11,151
100		CULBERTSON GARDENS	1,810			14,762		14,762
100	01	MEDICAL ARTS BUILDING				31,513		31,513
100	02	FOUNDATION				1,448		1,448
101		CROSS FOOT ADJUSTMENTS						
102		NEGATIVE COST CENTER						
103		TOTAL	24,708	3,522	59,042	752,523		752,523

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET B-1

		COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-RHCS BL (SQUARE FEET)	NEW CAP REL COSTS-MED ART (SQUARE FEET)	NEW CAP REL COSTS-MVBLE E (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION
			3	3.01	3.02	4	5	6a.04
		GENERAL SERVICE COST						
003		NEW CAP REL COSTS-BLD	56,479					
003	01	NEW CAP REL COSTS-RHC		11,800				
003	02	NEW CAP REL COSTS-MED			9,400			
004		NEW CAP REL COSTS-MVB				56,479		
005		EMPLOYEE BENEFITS					7,320,669	
006	04	HOSPITAL ONLY ADMIN &	3,104			3,104	393,599	-746,706
006	05	OTHER ADMINISTRATIVE	7,327			7,327	813,110	-1,981,632
007		MAINTENANCE & REPAIRS	5,407			5,407	174,286	
008		OPERATION OF PLANT					57,399	
008	01	PLANT & HSKPG - RHCS						
010		HOUSEKEEPING	1,948			1,948	262,136	
011		DIETARY	2,766			2,766	306,946	
012		CAFETERIA	945			945		
014		NURSING ADMINISTRATIO	120			120	113,068	
017		MEDICAL RECORDS & LIB	3,583			3,583	368,076	
		INPAT ROUTINE SRVC CN						
025		ADULTS & PEDIATRICS	5,945			5,945	724,194	
036		OTHER LONG TERM CARE	8,454			8,454	449,128	
		ANCILLARY SRVC COST C						
037		OPERATING ROOM	2,565			2,565	127,772	
040		ANESTHESIOLOGY					133,309	
041		RADIOLOGY-DIAGNOSTIC	3,183			3,183	359,444	
044		LABORATORY	929			929	403,565	
046		WHOLE BLOOD & PACKED	100			100		
049		RESPIRATORY THERAPY	630			630		
050		PHYSICAL THERAPY	2,925			2,925	475,304	
053		ELECTROCARDIOLOGY					77,267	
055		MEDICAL SUPPLIES CHAR						
056		DRUGS CHARGED TO PATI	611			611		
		OUTPAT SERVICE COST C						
060		CLINIC	3,531			3,531	85,983	
061		EMERGENCY	2,305			2,305	403,064	
062		OBSERVATION BEDS (NON						
063		OTHER OUTPATIENT SERV						
063	50	RURAL HEALTH CLINIC		11,800			1,179,130	
		SPEC PURPOSE COST CEN						
095		SUBTOTALS	56,378	11,800		56,378	6,906,780	-2,728,338
		NONREIMBURS COST CENT						
096		GIFT, FLOWER, COFFEE						
098		PHYSICIANS' PRIVATE O			2,100		251,119	-349,509
100		CULBERTSON GARDENS					162,770	-369,613
100	01	MEDICAL ARTS BUILDING			7,300			-31,321
100	02	FOUNDATION	101			101		-1,191
101		CROSS FOOT ADJUSTMENT						
102		NEGATIVE COST CENTER						
103		COST TO BE ALLOCATED (WRKSHT B, PART I)	185,309	46,193	40,331	480,690	1,465,411	
104		UNIT COST MULTIPLIER (WRKSHT B, PT I)	3.281025	3.914661	4.290532	8.510951	.200174	
105		COST TO BE ALLOCATED (WRKSHT B, PART II)						
106		UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107		COST TO BE ALLOCATED (WRKSHT B, PART III						
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)						

		COST CENTER DESCRIPTION	HOSPITAL ONLY ADMIN & GEN (ACCUM. COST	) RECONCIL- IATION	OTHER ADMINIS TRATIVE AND (ACCUM. COST	MAINTENANCE & REPAIRS (SQUARE)FEET	OPERATION OF PLANT (SQUARE)FEET	PLANT & HSKPG - RHCS (SQUARE)FEET	HOUSEKEEPING (SQUARE)FEET
			6.04	6a.05	6.05	7	8	8.01	10
		GENERAL SERVICE COST							
003		NEW CAP REL COSTS-BLD							
003	01	NEW CAP REL COSTS-RHC							
003	02	NEW CAP REL COSTS-MED							
004		NEW CAP REL COSTS-MVB							
005		EMPLOYEE BENEFITS							
006	04	HOSPITAL ONLY ADMIN &	12,604,245						
006	05	OTHER ADMINISTRATIVE		-1,981,632	14,102,585				
007		MAINTENANCE & REPAIRS	342,108		362,375	40,641			
008		OPERATION OF PLANT	245,553		260,100		40,641		
008	01	PLANT & HSKPG - RHCS	36,154		38,296			11,800	
010		HOUSEKEEPING	380,917		403,483	1,948	1,948		38,693
011		DIETARY	604,035		639,819	2,766	2,766		2,766
012		CAFETERIA	11,144		11,804	945	945		945
014		NURSING ADMINISTRATIO	155,392		164,598	120	120		120
017		MEDICAL RECORDS & LIB	541,804		573,902	3,583	3,583		3,583
		INPAT ROUTINE SRVC CN							
025		ADULTS & PEDIATRICS	1,054,051		1,116,495	5,945	5,945		5,945
036		OTHER LONG TERM CARE	682,179		722,593	8,454	8,454		8,454
		ANCILLARY SRVC COST C							
037		OPERATING ROOM	284,996		301,880	2,565	2,565		2,565
040		ANESTHESIOLOGY	263,663		279,283				
041		RADIOLOGY-DIAGNOSTIC	887,453		940,027	3,183	3,183		3,183
044		LABORATORY	1,209,351		1,280,995	929	929		929
046		WHOLE BLOOD & PACKED	58,593		62,064	100	100		100
049		RESPIRATORY THERAPY	165,096		174,877	630	630		630
050		PHYSICAL THERAPY	680,727		721,055	2,925	2,925		2,925
053		ELECTROCARDIOLOGY	251,103		265,979				
055		MEDICAL SUPPLIES CHAR							
056		DRUGS CHARGED TO PATI	751,388		795,902	611	611		611
		OUTPAT SERVICE COST C							
060		CLINIC	610,430		646,593	3,531	3,531		3,531
061		EMERGENCY	1,306,663		1,384,072	2,305	2,305		2,305
062		OBSERVATION BEDS (NON							
063		OTHER OUTPATIENT SERV							
063	50	RURAL HEALTH CLINIC	2,081,445		2,204,759			11,800	
		SPEC PURPOSE COST CEN							
095		SUBTOTALS	12,604,245	-1,981,632	13,350,951	40,540	40,540	11,800	38,592
		NONREIMBURS COST CENT							
096		GIFT, FLOWER, COFFEE							
098		PHYSICIANS' PRIVATE O			349,509				
100		CULBERTSON GARDENS			369,613				
100	01	MEDICAL ARTS BUILDING			31,321				
100	02	FOUNDATION			1,191	101	101		101
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		COST TO BE ALLOCATED (WRKSHT B, PART I)	746,706		1,981,632	413,294	296,648	43,677	494,208
104		UNIT COST MULTIPLIER (WRKSHT B, PT I)	.059242		.140516	10.169386	7.299230	3.701441	12.772543
105		COST TO BE ALLOCATED (WRKSHT B, PART II)							
106		UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107		COST TO BE ALLOCATED (WRKSHT B, PART III	36,602		86,400	66,973	2,307	340	29,869
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)	.002904		.006127	1.647917	.056765	.028814	.771948

		COST CENTER DESCRIPTION	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)
			11	12	14	17
		GENERAL SERVICE COST				
003		NEW CAP REL COSTS-BLD				
003	01	NEW CAP REL COSTS-RHC				
003	02	NEW CAP REL COSTS-MED				
004		NEW CAP REL COSTS-MVB				
005		EMPLOYEE BENEFITS				
006	04	HOSPITAL ONLY ADMIN &				
006	05	OTHER ADMINISTRATIVE				
007		MAINTENANCE & REPAIRS				
008		OPERATION OF PLANT				
008	01	PLANT & HSKPG - RHCS				
010		HOUSEKEEPING				
011		DIETARY	53,439			
012		CAFETERIA	13,164	8,052		
014		NURSING ADMINISTRATIO		114	90,238	
017		MEDICAL RECORDS & LIB		922		8,891
		INPAT ROUTINE SRVC CN				
025		ADULTS & PEDIATRICS	7,188	1,565	33,351	2,107
036		OTHER LONG TERM CARE	20,435	1,313	27,979	114
		ANCILLARY SRVC COST C				
037		OPERATING ROOM		199	4,245	
040		ANESTHESIOLOGY		93		
041		RADIOLOGY-DIAGNOSTIC		644		1,341
044		LABORATORY		744		448
046		WHOLE BLOOD & PACKED				
049		RESPIRATORY THERAPY				94
050		PHYSICAL THERAPY		711		70
053		ELECTROCARDIOLOGY		152	3,248	339
055		MEDICAL SUPPLIES CHAR				
056		DRUGS CHARGED TO PATI				
		OUTPAT SERVICE COST C				
060		CLINIC		184	3,922	1,115
061		EMERGENCY		821	17,493	1,313
062		OBSERVATION BEDS (NON				
063		OTHER OUTPATIENT SERV				
063	50	RURAL HEALTH CLINIC				1,950
		SPEC PURPOSE COST CEN				
095		SUBTOTALS	40,787	7,462	90,238	8,891
		NONREIMBURS COST CENT				
096		GIFT, FLOWER, COFFEE				
098		PHYSICIANS' PRIVATE O				
100		CULBERTSON GARDENS	12,652	590		
100	01	MEDICAL ARTS BUILDING				
100	02	FOUNDATION				
101		CROSS FOOT ADJUSTMENT				
102		NEGATIVE COST CENTER				
103		COST TO BE ALLOCATED (PER WRKSHT B, PART	813,372	242,405	194,788	790,655
104		UNIT COST MULTIPLIER (WRKSHT B, PT I)	15.220569	30.104943	2.158603	88.927567
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	45,140	24,708	3,522	59,042
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)	.844701	3.068554	.039030	6.640648

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1333 | PERIOD: FROM 3/ 1/2009 TO 2/28/2010 | PREPARED 6/16/2010 | WORKSHEET C PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
			1	2	3	4	5
		INPAT ROUTINE SRVC CNTRS					
25		ADULTS & PEDIATRICS	1,869,044		1,869,044		
36		OTHER LONG TERM CARE	1,500,880		1,500,880		
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	437,022		437,022		
40		ANESTHESIOLOGY	321,327		321,327		
41		RADIOLOGY-DIAGNOSTIC	1,307,013		1,307,013		
44		LABORATORY	1,551,327		1,551,327		
46		WHOLE BLOOD & PACKED RED	73,809		73,809		
49		RESPIRATORY THERAPY	226,862		226,862		
50		PHYSICAL THERAPY	938,460		938,460		
53		ELECTROCARDIOLOGY	345,086		345,086		
55		MEDICAL SUPPLIES CHARGED					
56		DRUGS CHARGED TO PATIENTS	926,216		926,216		
		OUTPAT SERVICE COST CNTRS					
60		CLINIC	957,391		957,391		
61		EMERGENCY	1,827,500		1,827,500		
62		OBSERVATION BEDS (NON-DIS	304,126		304,126		
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC	2,731,642		2,731,642		
		OTHER REIMBURS COST CNTRS					
101		SUBTOTAL	15,317,705		15,317,705		
102		LESS OBSERVATION BEDS	304,126		304,126		
103		TOTAL	15,013,579		15,013,579		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET C 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 INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	1,426,755		1,426,755			
36		OTHER LONG TERM CARE	844,612		844,612			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	54,927	1,343,566	1,398,493	.312495	.312495	
40		ANESTHESIOLOGY	34,163	471,994	506,157	.634837	.634837	
41		RADIOLOGY-DIAGNOSTIC	222,867	5,991,565	6,214,432	.210319	.210319	
44		LABORATORY	356,679	4,013,814	4,370,493	.354955	.354955	
46		WHOLE BLOOD & PACKED RED	49,510	106,778	156,288	.472263	.472263	
49		RESPIRATORY THERAPY	235,290	464,814	700,104	.324040	.324040	
50		PHYSICAL THERAPY	269,794	1,812,601	2,082,395	.450664	.450664	
53		ELECTROCARDIOLOGY	150,157	1,634,781	1,784,938	.193332	.193332	
55		MEDICAL SUPPLIES CHARGED						
56		DRUGS CHARGED TO PATIENTS	1,264,249	1,580,641	2,844,890	.325572	.325572	
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	7,804	1,435,531	1,443,335	.663319	.663319	
61		EMERGENCY	25,776	2,468,844	2,494,620	.732577	.732577	
62		OBSERVATION BEDS (NON-DIS	4,339	306,853	311,192	.977294	.977294	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		2,151,685	2,151,685	1.269536	1.269536	
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	4,946,922	23,783,467	28,730,389			
102		LESS OBSERVATION BEDS						
103		TOTAL	4,946,922	23,783,467	28,730,389			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 14-1333
PERIOD: FROM 3/ 1/2009 TO 2/28/2010

PREPARED 6/16/2010
WORKSHEET C
PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	1,869,044		1,869,044		
36	OTHER LONG TERM CARE	1,500,880		1,500,880		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	437,022		437,022		
40	ANESTHESIOLOGY	321,327		321,327		
41	RADIOLOGY-DIAGNOSTIC	1,307,013		1,307,013		
44	LABORATORY	1,551,327		1,551,327		
46	WHOLE BLOOD & PACKED RED	73,809		73,809		
49	RESPIRATORY THERAPY	226,862		226,862		
50	PHYSICAL THERAPY	938,460		938,460		
53	ELECTROCARDIOLOGY	345,086		345,086		
55	MEDICAL SUPPLIES CHARGED					
56	DRUGS CHARGED TO PATIENTS	926,216		926,216		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	957,391		957,391		
61	EMERGENCY	1,827,500		1,827,500		
62	OBSERVATION BEDS (NON-DIS	304,126		304,126		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	2,731,642		2,731,642		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	15,317,705		15,317,705		
102	LESS OBSERVATION BEDS	304,126		304,126		
103	TOTAL	15,013,579		15,013,579		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET C 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 INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	1,426,755		1,426,755			
36		OTHER LONG TERM CARE	844,612		844,612			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	54,927	1,343,566	1,398,493	.312495	.312495	
40		ANESTHESIOLOGY	34,163	471,994	506,157	.634837	.634837	
41		RADIOLOGY-DIAGNOSTIC	222,867	5,991,565	6,214,432	.210319	.210319	
44		LABORATORY	356,679	4,013,814	4,370,493	.354955	.354955	
46		WHOLE BLOOD & PACKED RED	49,510	106,778	156,288	.472263	.472263	
49		RESPIRATORY THERAPY	235,290	464,814	700,104	.324040	.324040	
50		PHYSICAL THERAPY	269,794	1,812,601	2,082,395	.450664	.450664	
53		ELECTROCARDIOLOGY	150,157	1,634,781	1,784,938	.193332	.193332	
55		MEDICAL SUPPLIES CHARGED						
56		DRUGS CHARGED TO PATIENTS	1,264,249	1,580,641	2,844,890	.325572	.325572	
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	7,804	1,435,531	1,443,335	.663319	.663319	
61		EMERGENCY	25,776	2,468,844	2,494,620	.732577	.732577	
62		OBSERVATION BEDS (NON-DIS	4,339	306,853	311,192	.977294	.977294	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		2,151,685	2,151,685	1.269536	1.269536	
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	4,946,922	23,783,467	28,730,389			
102		LESS OBSERVATION BEDS						
103		TOTAL	4,946,922	23,783,467	28,730,389			

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	437,022	40,055	396,967			437,022
40		ANESTHESIOLOGY	321,327	2,762	318,565			321,327
41		RADIOLOGY-DIAGNOSTIC	1,307,013	64,635	1,242,378			1,307,013
44		LABORATORY	1,551,327	29,875	1,521,452			1,551,327
46		WHOLE BLOOD & PACKED RED	73,809	1,977	71,832			73,809
49		RESPIRATORY THERAPY	226,862	11,163	215,699			226,862
50		PHYSICAL THERAPY	938,460	50,778	887,682			938,460
53		ELECTROCARDIOLOGY	345,086	5,203	339,883			345,086
55		MEDICAL SUPPLIES CHARGED						
56		DRUGS CHARGED TO PATIENTS	926,216	15,777	910,439			926,216
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	957,391	64,239	893,152			957,391
61		EMERGENCY	1,827,500	57,085	1,770,415			1,827,500
62		OBSERVATION BEDS (NON-DIS	304,126		304,126			304,126
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	2,731,642	79,030	2,652,612			2,731,642
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	11,947,781	422,579	11,525,202			11,947,781
102		LESS OBSERVATION BEDS	304,126		304,126			304,126
103		TOTAL	11,643,655	422,579	11,221,076			11,643,655

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	1,398,493	.312495	.312495
40		ANESTHESIOLOGY	506,157	.634837	.634837
41		RADIOLOGY-DIAGNOSTIC	6,214,432	.210319	.210319
44		LABORATORY	4,370,493	.354955	.354955
46		WHOLE BLOOD & PACKED RED	156,288	.472263	.472263
49		RESPIRATORY THERAPY	700,104	.324040	.324040
50		PHYSICAL THERAPY	2,082,395	.450664	.450664
53		ELECTROCARDIOLOGY	1,784,938	.193332	.193332
55		MEDICAL SUPPLIES CHARGED			
56		DRUGS CHARGED TO PATIENTS	2,844,890	.325572	.325572
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	1,443,335	.663319	.663319
61		EMERGENCY	2,494,620	.732577	.732577
62		OBSERVATION BEDS (NON-DIS	311,192	.977294	.977294
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	2,151,685	1.269536	1.269536
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	26,459,022		
102		LESS OBSERVATION BEDS	311,192		
103		TOTAL	26,147,830		

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	437,022	40,055	396,967			437,022
40		ANESTHESIOLOGY	321,327	2,762	318,565			321,327
41		RADIOLOGY-DIAGNOSTIC	1,307,013	64,635	1,242,378			1,307,013
44		LABORATORY	1,551,327	29,875	1,521,452			1,551,327
46		WHOLE BLOOD & PACKED RED	73,809	1,977	71,832			73,809
49		RESPIRATORY THERAPY	226,862	11,163	215,699			226,862
50		PHYSICAL THERAPY	938,460	50,778	887,682			938,460
53		ELECTROCARDIOLOGY	345,086	5,203	339,883			345,086
55		MEDICAL SUPPLIES CHARGED						
56		DRUGS CHARGED TO PATIENTS	926,216	15,777	910,439			926,216
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	957,391	64,239	893,152			957,391
61		EMERGENCY	1,827,500	57,085	1,770,415			1,827,500
62		OBSERVATION BEDS (NON-DIS	304,126		304,126			304,126
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	2,731,642	79,030	2,652,612			2,731,642
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	11,947,781	422,579	11,525,202			11,947,781
102		LESS OBSERVATION BEDS	304,126		304,126			304,126
103		TOTAL	11,643,655	422,579	11,221,076			11,643,655

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	1,398,493	.312495	.312495
40		ANESTHESIOLOGY	506,157	.634837	.634837
41		RADIOLOGY-DIAGNOSTIC	6,214,432	.210319	.210319
44		LABORATORY	4,370,493	.354955	.354955
46		WHOLE BLOOD & PACKED RED	156,288	.472263	.472263
49		RESPIRATORY THERAPY	700,104	.324040	.324040
50		PHYSICAL THERAPY	2,082,395	.450664	.450664
53		ELECTROCARDIOLOGY	1,784,938	.193332	.193332
55		MEDICAL SUPPLIES CHARGED			
56		DRUGS CHARGED TO PATIENTS	2,844,890	.325572	.325572
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	1,443,335	.663319	.663319
61		EMERGENCY	2,494,620	.732577	.732577
62		OBSERVATION BEDS (NON-DIS	311,192	.977294	.977294
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	2,151,685	1.269536	1.269536
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	26,459,022		
102		LESS OBSERVATION BEDS	311,192		
103		TOTAL	26,147,830		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET C I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	TOTAL ANCILLARY CHARGES	TOTAL INP ANCILLARY CHARGES	CHARGE TO CHARGE RATIO	TOTAL INPATIENT COST
		1	2	3	4	5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	437,022	1,398,493			
40	ANESTHESIOLOGY	321,327	506,157			
41	RADIOLOGY-DIAGNOSTIC	1,307,013	6,214,432			
44	LABORATORY	1,551,327	4,370,493			
46	WHOLE BLOOD & PACKED RED	73,809	156,288			
49	RESPIRATORY THERAPY	226,862	700,104			
50	PHYSICAL THERAPY	938,460	2,082,395			
53	ELECTROCARDIOLOGY	345,086	1,784,938			
55	MEDICAL SUPPLIES CHARGED					
56	DRUGS CHARGED TO PATIENTS	926,216	2,844,890			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	957,391	1,443,335			
61	EMERGENCY	1,827,500	2,494,620			
62	OBSERVATION BEDS (NON-DIS	304,126	311,192			
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	2,731,642	2,151,685			
	OTHER REIMBURS COST CNTRS					
101	TOTAL	11,947,781	26,459,022			

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET C I PART V

WKST A LINE	NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	PROVIDER-BASED PHYSICIAN ADJUSTMENT	TOTAL COSTS	TOTAL ANCILLARY CHARGES	TOTAL OUTPATIENT CHARGES	RATIO OF OUT-PATIENT CHRGS TO TTL CHARGES	TOTAL OUT-PATIENT COSTS
			1	2	3	4	5	6	7
		ANCILLARY SRVC COST CNTRS							
37		OPERATING ROOM	437,022		437,022	1,398,493			
40		ANESTHESIOLOGY	321,327		321,327	506,157			
41		RADIOLOGY-DIAGNOSTIC	1,307,013	1,590	1,308,603	6,214,432			
44		LABORATORY	1,551,327		1,551,327	4,370,493			
46		WHOLE BLOOD & PACKED RED	73,809		73,809	156,288			
49		RESPIRATORY THERAPY	226,862		226,862	700,104			
50		PHYSICAL THERAPY	938,460		938,460	2,082,395			
53		ELECTROCARDIOLOGY	345,086	39,463	384,549	1,784,938			
55		MEDICAL SUPPLIES CHARGED							
56		DRUGS CHARGED TO PATIENTS	926,216		926,216	2,844,890			
		OUTPAT SERVICE COST CNTRS							
60		CLINIC	957,391	341,183	1,298,574	1,443,335			
61		EMERGENCY	1,827,500	373,615	2,201,115	2,494,620			
62		OBSERVATION BEDS (NON-DIS	304,126		304,126	311,192			
63		OTHER OUTPATIENT SERVICE							
63	50	RURAL HEALTH CLINIC							
		OTHER REIMBURS COST CNTRS							
101		TOTAL	9,216,139	755,851	9,971,990	24,307,337			
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: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET D PART V

I COMPONENT NO: 14-1333 I I

TITLE XVIII, PART B HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
	Cost Center Description	1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.312495		.312495		
40	ANESTHESIOLOGY	.634837		.634837		
41	RADIOLOGY-DIAGNOSTIC	.210319		.210319		
44	LABORATORY	.354955		.354955		
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.472263		.472263		
49	RESPIRATORY THERAPY	.324040		.324040		
50	PHYSICAL THERAPY	.450664		.450664		
53	ELECTROCARDIOLOGY	.193332		.193332		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS	.325572		.325572		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	.663319		.663319		
61	EMERGENCY	.732577		.732577		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.977294		.977294		
63	OTHER OUTPATIENT SERVICE COST CENTER					
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

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 2/28/2010	PART V
14-1333		

TITLE XVIII, PART B HOSPITAL

(A)	Cost Center Description	Other Outpatient Diagnostic 4	All Other (1) 5	Outpatient Ambulatory Surgical Ctr 6	Outpatient Radialogy 7	Other Outpatient Diagnostic 8
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		637,963			
40	ANESTHESIOLOGY		205,874			
41	RADIOLOGY-DIAGNOSTIC		2,287,759			
44	LABORATORY		1,829,606			
46	WHOLE BLOOD & PACKED RED BLOOD CELLS		90,065			
49	RESPIRATORY THERAPY		181,512			
50	PHYSICAL THERAPY		883,592			
53	ELECTROCARDIOLOGY		935,085			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS		864,565			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC		743,014			
61	EMERGENCY		1,192,315			
62	OBSERVATION BEDS (NON-DISTINCT PART)		193,501			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL		10,044,851			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		10,044,851			

(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

PROVIDER NO: 14-1333	PERIOD: FROM 3/ 1/2009 TO 2/28/2010	PREPARED 6/16/2010
COMPONENT NO: 14-1333		WORKSHEET D PART V

TITLE XVIII, PART B HOSPITAL

		Cost Center Description	All Other 9	Hospital I/P Part B Charges 10	Hospital I/P Part B Costs 11
(A)		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	199,360		
40		ANESTHESIOLOGY	130,696		
41		RADIOLOGY-DIAGNOSTIC	481,159		
44		LABORATORY	649,428		
46		WHOLE BLOOD & PACKED RED BLOOD CELLS	42,534		
49		RESPIRATORY THERAPY	58,817		
50		PHYSICAL THERAPY	398,203		
53		ELECTROCARDIOLOGY	180,782		
55		MEDICAL SUPPLIES CHARGED TO PATIENTS			
56		DRUGS CHARGED TO PATIENTS	281,478		
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	492,855		
61		EMERGENCY	873,463		
62		OBSERVATION BEDS (NON-DISTINCT PART)	189,107		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
101		SUBTOTAL	3,977,882		
102		CRNA CHARGES			
103		LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104		NET CHARGES	3,977,882		

(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

PROVIDER NO:	PERIOD:		PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009		WORKSHEET D
COMPONENT NO:	TO 2/28/2010		PART VI
14-1333			

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.325572
2	PROGRAM VACCINE CHARGES	6,234
3	PROGRAM COSTS	2,030

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 2/28/2010	PART I
14-1333		

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)	2,501
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,436
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,436
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	798
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)	130
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	77
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)	60
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	761
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	798
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)	130
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	117.42
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.42
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1,869,044
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	9,041
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	7,045
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	743,471
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,125,573
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,022,992
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,022,992
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.100275
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	712.39
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,125,573

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 2/28/2010	PART II
14-1333		

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	783.82
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	596,487
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	596,487

		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					
						1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					415,152
49	TOTAL PROGRAM INPATIENT COSTS					1,011,639

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)	625,488
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	101,897
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	727,385
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	

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 2/28/2010	PART III
14-1333		

TITLE XVIII PART A HOSPITAL OTHER

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

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
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	388
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	783.83
85	OBSERVATION BED COST	304,126

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

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET D-4
COMPONENT NO:	TO 2/28/2010	
14-1333		

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.		COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS		716,359	
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.312495	1,835	573
40		ANESTHESIOLOGY	.634837	3,639	2,310
41		RADIOLOGY-DIAGNOSTIC	.210319	152,587	32,092
44		LABORATORY	.354955	205,072	72,791
46		WHOLE BLOOD & PACKED RED BLOOD CELLS	.472263	37,636	17,774
49		RESPIRATORY THERAPY	.324040	167,939	54,419
50		PHYSICAL THERAPY	.450664	30,382	13,692
53		ELECTROCARDIOLOGY	.193332	107,904	20,861
55		MEDICAL SUPPLIES CHARGED TO PATIENTS			
56		DRUGS CHARGED TO PATIENTS	.325572	609,392	198,401
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	.663319	3,375	2,239
61		EMERGENCY	.732577		
62		OBSERVATION BEDS (NON-DISTINCT PART)	.977294		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
		OTHER REIMBURS COST CNTRS			
101		TOTAL		1,319,761	415,152
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		1,319,761	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1333 I PERIOD: I FROM 3/ 1/2009 I TO 2/28/2010 I PREPARED 6/16/2010 I WORKSHEET D-4

I COMPONENT NO: 14-Z333 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
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.312495		
40	ANESTHESIOLOGY	.634837		
41	RADIOLOGY-DIAGNOSTIC	.210319	13,242	2,785
44	LABORATORY	.354955	81,050	28,769
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.472263	3,555	1,679
49	RESPIRATORY THERAPY	.324040	43,143	13,980
50	PHYSICAL THERAPY	.450664	183,177	82,551
53	ELECTROCARDIOLOGY	.193332	10,438	2,018
55	MEDICAL SUPPLIES CHARGED TO PATIENTS			
56	DRUGS CHARGED TO PATIENTS	.325572	250,046	81,408
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.663319	3,171	2,103
61	EMERGENCY	.732577		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.977294		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		587,822	215,293
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		587,822	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET E
COMPONENT NO:	TO 2/28/2010	PART B
14-1333		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,979,912
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)	3,979,912
	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)	4,019,711
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	50,637
18.01	CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	1,629,004
19	SUBTOTAL (SEE INSTRUCTIONS)	2,340,070
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	2,340,070
24	PRIMARY PAYER PAYMENTS	968
25	SUBTOTAL	2,339,102
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	318,272
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	318,272
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	318,272
28	SUBTOTAL	2,657,374
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	2,657,374
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,290,757
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	366,617
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

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 2/28/2010	
14-1333		

TITLE XVIII HOSPITAL

	DESCRIPTION			INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				699,260		2,290,757
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.				NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
		ADJUSTMENTS TO PROVIDER	.01	6/ 3/2009	134,300		
		ADJUSTMENTS TO PROVIDER	.02	11/19/2009	10,400		
		ADJUSTMENTS TO PROVIDER	.03	3/ 5/2010	73,700		
		ADJUSTMENTS TO PROVIDER	.04				
		ADJUSTMENTS TO PROVIDER	.05				
		ADJUSTMENTS TO PROGRAM	.50	5/28/2010	29,300		
		ADJUSTMENTS TO PROGRAM	.51				
		ADJUSTMENTS TO PROGRAM	.52				
		ADJUSTMENTS TO PROGRAM	.53				
		ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL		.99		189,100		NONE
4	TOTAL INTERIM PAYMENTS				888,360		2,290,757
	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		7,899		366,617
		SETTLEMENT TO PROGRAM	.02				
7	TOTAL MEDICARE PROGRAM LIABILITY				896,259		2,657,374

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 2/28/2010	
14-Z333		

TITLE XVIII SWING BED SNF

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,073,782		
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01	8/17/2009	19,400		
	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		19,400		NONE
4	TOTAL INTERIM PAYMENTS			1,093,182		
	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		165,520		
7	TOTAL MEDICARE PROGRAM LIABILITY			927,662		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	
COMPONENT NO:	TO 2/28/2010	WORKSHEET E-2
14-Z333		

TITLE XVIII SWING BED SNF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	734,659	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	217,446	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	928	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	952,105	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	952,105	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	952,105	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	24,443	
14	80% OF PART B COSTS		
15	SUBTOTAL	927,662	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	927,662	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,093,182	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-165,520	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 2/28/2010	PART II
14-1333		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT
HOSPITAL

1	INPATIENT SERVICES	1,011,639
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	1,011,639
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	1,021,755
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	1,021,755
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	160,742
21	EXCESS REASONABLE COST	
22	SUBTOTAL	861,013
23	COINSURANCE	
24	SUBTOTAL	861,013
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	35,246
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	35,246
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	35,246
26	SUBTOTAL	896,259
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER 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	896,259
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	888,360
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	7,899
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET | PROVIDER NO: 14-1333 | PERIOD: FROM 3/ 1/2009 TO 2/28/2010 | PREPARED 6/16/2010 | WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	2,194,184			
2	TEMPORARY INVESTMENTS	1,666,540			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	3,782,491			
5	OTHER RECEIVABLES	564,435			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	434,403			
8	PREPAID EXPENSES	112,196			
9	OTHER CURRENT ASSETS	113,089			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	8,867,338			
	FIXED ASSETS				
12	LAND	289,461			
12.01					
13	LAND IMPROVEMENTS	719,040			
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	7,165,516			
14.01	LESS ACCUMULATED DEPRECIATION	-7,798,186			
15	LEASEHOLD IMPROVEMENTS	207,432			
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	129,018			
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	4,864,137			
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE	37,417			
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	5,613,835			
	OTHER ASSETS				
22	INVESTMENTS	1,930,014			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	141,607			
26	TOTAL OTHER ASSETS	2,071,621			
27	TOTAL ASSETS	16,552,794			

BALANCE SHEET | PROVIDER NO: 14-1333 | PERIOD: FROM 3/ 1/2009 TO 2/28/2010 | PREPARED 6/16/2010 | WORKSHEET G

	LIABILITIES AND FUND BALANCE	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	638,344			
29	SALARIES, WAGES & FEES PAYABLE	998,111			
30	PAYROLL TAXES PAYABLE				
31	NOTES AND LOANS PAYABLE (SHORT TERM)	369,390			
32	DEFERRED INCOME	80,634			
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES				
36	TOTAL CURRENT LIABILITIES	2,086,479			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE				
38	NOTES PAYABLE	1,546,831			
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	1,546,831			
43	TOTAL LIABILITIES	3,633,310			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	12,919,484			
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	12,919,484			
52	TOTAL LIABILITIES AND FUND BALANCES	16,552,794			

STATEMENT OF CHANGES IN FUND BALANCES

PROVIDER NO:	PERIOD:	PREPARED
14-1333	FROM 3/ 1/2009	WORKSHEET G-1
	TO 2/28/2010	

		GENERAL FUND	SPECIFIC PURPOSE FUND
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD	12,089,319			
2	NET INCOME (LOSS)	830,165			
3	TOTAL	12,919,484			
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL	12,919,484			
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	12,919,484			

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER NO: 14-1333 | PERIOD: FROM 3/ 1/2009 TO 2/28/2010 | PREPARED 6/16/2010 | WORKSHEET G-2 | PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	1,022,992		1,022,992
4	00	SWING BED - SNF	411,048		411,048
5	00	SWING BED - NF			
8	00	OTHER LONG TERM CARE	840,319		840,319
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	2,274,359		2,274,359
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	2,274,359		2,274,359
17	00	ANCILLARY SERVICES	2,695,004	17,390,218	20,085,222
18	00	OUTPATIENT SERVICES	50,627	5,942,798	5,993,425
18	50	RURAL HEALTH CLINIC		3,116,956	3,116,956
24	00	PHYSICIAN CLINIC		332,147	332,147
24	01	CULBERTSON GARDENS		345,465	345,465
25	00	TOTAL PATIENT REVENUES	5,019,990	27,127,584	32,147,574

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES	17,493,861
		ADD (SPECIFY)	
27	00	ADD (SPECIFY)	
28	00		
29	00		
30	00		
31	00		
32	00		
33	00	TOTAL ADDITIONS	
		DEDUCT (SPECIFY)	
34	00	DEDUCT (SPECIFY)	
35	00		
36	00		
37	00		
38	00		
39	00	TOTAL DEDUCTIONS	
40	00	TOTAL OPERATING EXPENSES	17,493,861

STATEMENT OF REVENUES AND EXPENSES | PROVIDER NO: 14-1333 | PERIOD: FROM 3/ 1/2009 TO 2/28/2010 | PREPARED 6/16/2010 | WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	32,147,574
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	14,738,514
3	NET PATIENT REVENUES	17,409,060
4	LESS: TOTAL OPERATING EXPENSES	17,493,861
5	NET INCOME FROM SERVICE TO PATIENTS	-84,801
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	55,624
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	2,963
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS,FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	19,644
23	GOVERNMENTAL APPROPRIATIONS	491,269
24	FOUNDATION INCOME	245,428
24.01	MEALS ON WHEELS	97,898
24.02	MISCELLANEOUS INCOME	283,079
24.03		
25	TOTAL OTHER INCOME	1,195,905
26	TOTAL	1,111,104
	OTHER EXPENSES	
27	LOSS ON DISPOSAL OF ASSET	94,200
28	FOUNDATION EXPENSES	186,737
29	ROUNDING	2
30	TOTAL OTHER EXPENSES	280,939
31	NET INCOME (OR LOSS) FOR THE PERIOD	830,165

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

PROVIDER NO:	PERIOD:	PREPARED
14-1333	FROM 3/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 2/28/2010	
14-3483		

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	402,307		402,307	12,000
2	PHYSICIAN ASSISTANT	165,806		165,806	
3	NURSE PRACTITIONER	82,569		82,569	
4	VISITING NURSE				
5	OTHER NURSE	290,382		290,382	
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN	69,633		69,633	-69,633
9	OTHER FACILITY HEALTH CARE STAFF COSTS				
10	SUBTOTAL (SUM OF LINES 1-9)	1,010,697		1,010,697	-57,633
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT		546,004	546,004	
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		6,843	6,843	
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)		552,847	552,847	
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		48,727	48,727	
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS		35,247	35,247	
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		83,974	83,974	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,010,697	636,821	1,647,518	-57,633
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS	226,067	109,309	335,376	-26,974
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	226,067	109,309	335,376	-26,974
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,236,764	746,130	1,982,894	-84,607

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

PROVIDER NO:	PERIOD:	PREPARED
14-1333	FROM 3/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 2/28/2010	
14-3483		

RHC 1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	414,307	-50,314	363,993
2	PHYSICIAN ASSISTANT	165,806		165,806
3	NURSE PRACTITIONER	82,569		82,569
4	VISITING NURSE			
5	OTHER NURSE	290,382		290,382
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	953,064	-50,314	902,750
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT	546,004	-41,238	504,766
12	PHYSICIAN SUPERVISION UNDER AGREEMENT	6,843		6,843
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)	552,847	-41,238	511,609
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	48,727		48,727
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS	35,247		35,247
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	83,974		83,974
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,589,885	-91,552	1,498,333
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	308,402	-7,517	300,885
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	308,402	-7,517	300,885
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,898,287	-99,069	1,799,218

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED
14-1333	FROM 3/ 1/2009	WORKSHEET M-2
COMPONENT NO:	TO 2/28/2010	
14-3483		

RHC 1

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	1.51	12,927	4,200	6,342
2	PHYSICIAN ASSISTANTS	1.66	4,495	2,100	3,486
3	NURSE PRACTITIONERS	.86	2,552	2,100	1,806
4	SUBTOTAL (SUM OF LINES 1-3)	4.03	19,974		11,634
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4.03	19,974		
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)	1,498,333
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)	1,498,333
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)	300,885
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	932,424
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	1,233,309
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	1,233,309
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	1,233,309
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	2,731,642

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED
14-1333	FROM 3/ 1/2009	WORKSHEET M-2
COMPONENT NO:	TO 2/28/2010	
14-3483		

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)	19,974
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	19,974
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

PROVIDER NO:	PERIOD:	PREPARED
14-1333	FROM 3/ 1/2009	6/16/2010
COMPONENT NO:	TO 2/28/2010	WORKSHEET M-3
14-3483		

TITLE XVIII RHC 1

	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	2,731,642
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	13,508
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	2,718,134
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	19,974
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	19,974
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	136.08

		CALCULATION OF LIMIT (1)	
		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	76.84	77.76
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	136.08	136.08
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	4,319	864
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	587,730	117,573
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)*		705,303
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		57,490
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		647,813
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		518,250
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		9,319
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		527,569
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)		527,569
25	INTERIM PAYMENTS		582,452
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		-54,883
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

PROVIDER NO:	PERIOD:		PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009		WORKSHEET M-4
COMPONENT NO:	TO 2/28/2010		
14-3483			

TITLE XVIII RHC 1

		PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1	HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	902,750	902,750	902,750	902,750
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000257	.002322		
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	232	2,096		
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)		5,081		
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	232	7,177		
6	TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	1,498,333	1,498,333	1,498,333	1,498,333
7	TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	1,233,309	1,233,309	1,233,309	1,233,309
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000155	.004790		
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	191	5,908		
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	423	13,085		
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	39	352		
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	10.85	37.17		
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	23	244		
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	250	9,069		
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		13,508		
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		9,319		

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

[X] RHC [ ] FQHC

PROVIDER NO:	PERIOD:	PREPARED 6/16/2010
14-1333	FROM 3/ 1/2009	WORKSHEET M-5
COMPONENT NO:	TO 2/28/2010	
14-3483		

RHC 1

	DESCRIPTION		PART B MM/DD/YYYY 1	PART B AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			582,452
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			582,452
	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		
		SETTLEMENT TO PROGRAM .02		54,883
7	TOTAL MEDICARE PROGRAM LIABILITY			527,569

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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(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.