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: 14-1344	PERIOD FROM 7/ 1/2009 TO 6/30/2010	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 11/23/2010 TIME 11:28

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:
LAWRENCE COUNTY MEMORIAL HOSPITAL 14-1344
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING 6/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 11/23/2010 TIME 11:28

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PI ENCRYPTION INFORMATION
DATE: 11/23/2010 TIME 11:28

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DQ6kK0PaWM2er98I2Ftrak2L4RGE8h
Hqt44uU6ZE0hdAn0

Gerald Illest
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

CFO
TITLE

11-23-2010
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX
		1	2	3	4
1	HOSPITAL	0	108,399	-193,016	0
3	SWING BED - SNF	0	50,087	0	0
9	RHC	0	0	38,270	0
100	TOTAL	0	158,486	-154,746	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 | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 2100 STATE STREET P.O. BOX: 62439

1.01 CITY: LAWRENCEVILLE STATE: IL ZIP CODE: 62439- COUNTY: LAWRENCE

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	LAWRENCE COUNTY MEMORIAL HOSPITAL	14-1344		4/ 1/2005	N	O	N
04.00	SWING BED - SNF	LAWRENCE COUTNY MEMORIAL HOSPITAL	14-Z344		4/ 1/2005	N	O	N
14.00	HOSPITAL-BASED RHC	LCMH PRIMARY CARE CLINIC	14-3499		3/26/2009	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2009 TO: 6/30/2010

		1	2
18	TYPE OF CONTROL	9	

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

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	N
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y 4/ 1/2005
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)	N
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	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?	Y		
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	N		
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	N		
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	N		
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).	N		
40.01	NAME: FI/CONTRACTOR NAME			FI/CONTRACTOR #
40.02	STREET: P.O. BOX:			
40.03	CITY: STATE: ZIP CODE: -			
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y		
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y		
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y		
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.	N	00/00/0000	
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?			
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).			

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

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

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		
	PREMIUMS:	43,970	
	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.	Y	
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).		
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	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? N
ENTER "Y" FOR YES AND "N" FOR NO.

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

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). Y 10/ 6/2010

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS -------- TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	25	9,125	57,144.00		1,793		307
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					561		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	25	9,125	57,144.00		2,354		307
12	TOTAL	25	9,125	57,144.00		2,354		307
13	RPCH VISITS							
14	SUBPROVIDER							
24	RURAL HEALTH CLINIC					2,810		3,836
25	TOTAL	25						
26	OBSERVATION BED DAYS							5
27	AMBULANCE TRIPS					1,236		
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / TITLE XIX ADMITTED 5.01	OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS / TOTAL ALL PATS 6	TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			2,345				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			561				
4	ADULTS & PED-SB NF			38				
5	TOTAL ADULTS AND PEDS			2,944				
12	TOTAL			2,944				
13	RPCH VISITS							
14	SUBPROVIDER							
24	RURAL HEALTH CLINIC			8,720				
25	TOTAL							
26	OBSERVATION BED DAYS		5	13		13		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS			31				
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					551	118	788
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		121.68			551	118	788
13	RPCH VISITS							
14	SUBPROVIDER							
24	RURAL HEALTH CLINIC		10.47					
25	TOTAL		132.15					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	14-1344	FROM 7/ 1/2009	WORKSHEET S-8
	COMPONENT NO: 14-3499	TO 6/30/2010	

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 2111 LEXINGTON AVENUE

1.01 CITY: LAWRENCEVILLE STATE: IL ZIP CODE: 62439 COUNTY:

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	800	1700		

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

		TITLE V	TITLE 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.		N	

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1344 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		278,503	278,503		278,503
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		341,042	341,042		341,042
5	0500	EMPLOYEE BENEFITS	1,558	1,744,911	1,746,469	28,499	1,774,968
6.01	0600	ADMINISTRATIVE & GENERAL	284,850	275,471	560,321		560,321
6.02	0630	PURCHASING, RECEIVING AND STORES	58,396	6,929	65,325		65,325
6.03	1160	COMMUNICATIONS		48,064	48,064		48,064
6.04	0660	OTHER ADMINISTRATIVE AND GENERAL	154,297	897,134	1,051,431	-28,499	1,022,932
7	0700	MAINTENANCE & REPAIRS	139,367	107,892	247,259		247,259
8	0800	OPERATION OF PLANT		116,040	116,040		116,040
9	0900	LAUNDRY & LINEN SERVICE		45,295	45,295		45,295
10	1000	HOUSEKEEPING	169,257	26,820	196,077		196,077
11	1100	DIETARY	189,829	158,948	348,777	-260,446	88,331
12	1200	CAFETERIA				260,446	260,446
14	1400	NURSING ADMINISTRATION	125,457	38,743	164,200		164,200
15	1500	CENTRAL SERVICES & SUPPLY					
16	1600	PHARMACY	155,982	19,801	175,783		175,783
17	1700	MEDICAL RECORDS & LIBRARY	173,996	61,886	235,882		235,882
18	1800	SOCIAL SERVICE	52,059	3,045	55,104		55,104
20	2000	NONPHYSICIAN ANESTHETISTS		10,422	10,422		10,422
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	783,197	47,914	831,111		831,111
31	3100	SUBPROVIDER					
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	164,632	145,807	310,439		310,439
40	4000	ANESTHESIOLOGY	4,400	283,763	288,163		288,163
41	4100	RADIOLOGY-DIAGNOSTIC	203,388	680,327	883,715		883,715
44	4400	LABORATORY	367,651	412,344	779,995		779,995
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		67,493	67,493		67,493
49	4900	RESPIRATORY THERAPY	142,600	22,281	164,881		164,881
50	5000	PHYSICAL THERAPY	106,896	14,362	121,258		121,258
50.01	3160	CARDIAC REHAB	13,597	958	14,555		14,555
53	5300	ELECTROCARDIOLOGY					
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		56,007	56,007		56,007
56	5600	DRUGS CHARGED TO PATIENTS		146,166	146,166		146,166
59	3950	OTHER ANCILLARY SERVICE COST CENTERS	35,393	8,464	43,857		43,857
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	53,260	314,916	368,176		368,176
61	6100	EMERGENCY	320,625	942,933	1,263,558		1,263,558
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4040	FAMILY PRACTICE					
63.50	6310	RURAL HEALTH CLINIC	353,067	506,903	859,970	11,969	871,939
		OTHER REIMBURS COST CNTRS					
65	6500	AMBULANCE SERVICES	395,947	72,717	468,664		468,664
		SPEC PURPOSE COST CENTERS					
95		SUBTOTALS	4,449,701	7,904,301	12,354,002	11,969	12,365,971
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES	1,589	26,778	28,367	-11,969	16,398
98.01	9801	RURAL HEALTH CLINC (NON-CERTIFIED)					
98.02	9802	LSC					
98.03	9803	PUBLIC RELATIONS					
100	7950	OTHER NONREIMBURSABLE COST CENTERS					
101		TOTAL	4,451,290	7,931,079	12,382,369	-0-	12,382,369

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | I PROVIDER NO: 14-1344 | I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 | I PREPARED 11/23/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT		278,503
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	-3,823	337,219
5	0500	EMPLOYEE BENEFITS	-567	1,774,401
6.01	0600	ADMINISTRATIVE & GENERAL	-26,540	533,781
6.02	0630	PURCHASING, RECEIVING AND STORES		65,325
6.03	1160	COMMUNICATIONS		48,064
6.04	0660	OTHER ADMINISTRATIVE AND GENERAL	-98,153	924,779
7	0700	MAINTENANCE & REPAIRS		247,259
8	0800	OPERATION OF PLANT		116,040
9	0900	LAUNDRY & LINEN SERVICE		45,295
10	1000	HOUSEKEEPING		196,077
11	1100	DIETARY		88,331
12	1200	CAFETERIA	-74,126	186,320
14	1400	NURSING ADMINISTRATION		164,200
15	1500	CENTRAL SERVICES & SUPPLY		
16	1600	PHARMACY		175,783
17	1700	MEDICAL RECORDS & LIBRARY	-5,229	230,653
18	1800	SOCIAL SERVICE		55,104
20	2000	NONPHYSICIAN ANESTHETISTS		10,422
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		831,111
31	3100	SUBPROVIDER		
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		310,439
40	4000	ANESTHESIOLOGY	-259,770	28,393
41	4100	RADIOLOGY-DIAGNOSTIC		883,715
44	4400	LABORATORY		779,995
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		67,493
49	4900	RESPIRATORY THERAPY		164,881
50	5000	PHYSICAL THERAPY		121,258
50.01	3160	CARDIAC REHAB	-370	14,185
53	5300	ELECTROCARDIOLOGY		
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-18,436	37,571
56	5600	DRUGS CHARGED TO PATIENTS		146,166
59	3950	OTHER ANCILLARY SERVICE COST CENTERS		43,857
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC	-297,733	70,443
61	6100	EMERGENCY	-210,022	1,053,536
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4040	FAMILY PRACTICE		
63.50	6310	RURAL HEALTH CLINIC	-56,390	815,549
		OTHER REIMBURS COST CNTRS		
65	6500	AMBULANCE SERVICES		468,664
		SPEC PURPOSE COST CENTERS		
95		SUBTOTALS	-1,051,159	11,314,812
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800	PHYSICIANS' PRIVATE OFFICES		16,398
98.01	9801	RURAL HEALTH CLINC (NON-CERTIFIED)		
98.02	9802	LSC		
98.03	9803	PUBLIC RELATIONS		
100	7950	OTHER NONREIMBURSABLE COST CENTERS		
101		TOTAL	-1,051,159	11,331,210

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I 14-1344
I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010
I PREPARED 11/23/2010 I NOT A CMS WORKSHEET

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6.01	ADMINISTRATIVE & GENERAL	0600	
6.02	PURCHASING, RECEIVING AND STORES	0630	PURCHASING, RECEIVING AND STORES
6.03	COMMUNICATIONS	1160	COMMUNICATIONS
6.04	OTHER ADMINISTRATIVE AND GENERAL	0660	OTHER ADMINISTRATIVE AND GENERAL
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
31	SUBPROVIDER	3100	
	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	
50.01	CARDIAC REHAB	3160	CARDIOPULMONARY
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	OTHER ANCILLARY SERVICE COST CENTERS	3950	OTHER ANCILLARY SERVICE COST CENTERS
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	FAMILY PRACTICE	4040	FAMILY PRACTICE
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	RURAL HEALTH CLINC (NON-CERTIFIED)	9801	PHYSICIANS' PRIVATE OFFICES
98.02	LSC	9802	PHYSICIANS' PRIVATE OFFICES
98.03	PUBLIC RELATIONS	9803	PHYSICIANS' PRIVATE OFFICES
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	INCREASE SALARY	INCREASE OTHER
		1	2	3	4	5
1	CAFETERIA RECLASS	A	CAFETERIA	12	141,753	118,693
2	EMPLOYEE BENEFIT RECLASS	B	EMPLOYEE BENEFITS	5		28,499
3	RHC UTILITIES RECLASS	C	RURAL HEALTH CLINIC	63.50		11,969
36	TOTAL RECLASSIFICATIONS				141,753	159,161

(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	DECREASE CODE (1)	DECREASE COST CENTER 6	DECREASE LINE NO 7	DECREASE SALARY 8	DECREASE OTHER 9	A-7 REF 10
1	CAFETERIA RECLASS	A	DIETARY	11	141,753	118,693	
2	EMPLOYEE BENEFIT RECLASS	B	OTHER ADMINISTRATIVE AND GENERAL	6.04		28,499	
3	RHC UTILITIES RECLASS	C	PHYSICIANS' PRIVATE OFFICES	98		11,969	
36	TOTAL RECLASSIFICATIONS				141,753	159,161	

(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 : CAFETERIA RECLASS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	260,446	DIETARY	11	260,446
TOTAL RECLASSIFICATIONS FOR CODE A			260,446			260,446

RECLASS CODE: B
EXPLANATION : EMPLOYEE BENEFIT RECLASS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	EMPLOYEE BENEFITS	5	28,499	OTHER ADMINISTRATIVE AND GENER	6.04	28,499
TOTAL RECLASSIFICATIONS FOR CODE B			28,499			28,499

RECLASS CODE: C
EXPLANATION : RHC UTILITIES RECLASS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RURAL HEALTH CLINIC	63.50	11,969	PHYSICIANS' PRIVATE OFFICES	98	11,969
TOTAL RECLASSIFICATIONS FOR CODE C			11,969			11,969

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS PURCHASES	ACQUISITIONS DONATION	ACQUISITIONS TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		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 PURCHASES	ACQUISITIONS DONATION	ACQUISITIONS TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND	20,150					20,150	
2	LAND IMPROVEMENTS	349,421					349,421	
3	BUILDINGS & FIXTURE	5,290,722	43,087		43,087		5,333,809	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	499,757					499,757	
6	MOVABLE EQUIPMENT	4,141,713	348,419		348,419		4,490,132	
7	SUBTOTAL	10,301,763	391,506		391,506		10,693,269	
8	RECONCILING ITEMS							
9	TOTAL	10,301,763	391,506		391,506		10,693,269	

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	5,833,566		5,833,566	.565066				
4	NEW CAP REL COSTS-MV	4,490,132		4,490,132	.434934				
5	TOTAL	10,323,698		10,323,698	1.000000				

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	215,888			42,262	20,353		278,503
4	NEW CAP REL COSTS-MV	307,952		29,387			-120	337,219
5	TOTAL	523,840		29,387	42,262	20,353	-120	615,722

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	215,888			42,262	20,353		278,503
4	NEW CAP REL COSTS-MV	307,952		33,090				341,042
5	TOTAL	523,840		33,090	42,262	20,353		619,545

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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).

	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	B	-3,703	NEW CAP REL COSTS-MVBLE E	4	11
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES	B	-18,436	MEDICAL SUPPLIES CHARGED	55	
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-451,741			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-74,126	CAFETERIA	12	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES	B	-5,229	MEDICAL RECORDS & LIBRARY	17	
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS					
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	MISC. REVENUE - ADMIN	B	-2,461	OTHER ADMINISTRATIVE AND	6.04	
38	PART B PHYSICIAN BILLING COSTS	A	-26,540	ADMINISTRATIVE & GENERAL	6.01	
39	TELEPHONE OFFSET	A	-120	NEW CAP REL COSTS-MVBLE E	4	14
40	TELEPHONE OFFSET	A	-2,087	OTHER ADMINISTRATIVE AND	6.04	
41	TELEPHONE OFFSET	A	-567	EMPLOYEE BENEFITS	5	
42	PHYSICIAN MALPRACTICE COSTS	A	-8,659	EMERGENCY	61	
43	PHYSICIAN RECRUITMENT	A	-47,868	OTHER ADMINISTRATIVE AND	6.04	
44	MISC. EXPENSE - ADMIN	A	-7,777	OTHER ADMINISTRATIVE AND	6.04	
45	DONATIONS EXPENSE	A	-8,517	OTHER ADMINISTRATIVE AND	6.04	
46	ADVERTISING - ADMIN	A	-24,118	OTHER ADMINISTRATIVE AND	6.04	
47	ADVERTISING - RHC	A	-190	RURAL HEALTH CLINIC	63.50	
48	LOBBYING EXPENSE	A	-5,325	OTHER ADMINISTRATIVE AND	6.04	
49	ADVERTISING - CLINIC	A	-25	CLINIC	60	
49.01	PHYSICIAN COSTS	A	-297,708	CLINIC	60	
49.02	COST OF RHC PHYSICIANS SPENT IN HOSP	A	-56,200	RURAL HEALTH CLINIC	63.50	
49.03	ANESTHESIA BENEFITS	A	-9,762	ANESTHESIOLOGY	40	
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,051,159			

(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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1344 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO.		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	50	1	CARDIAC REHAB	370	370					
2	61		EMERGENCY	885,624	201,363	684,261				
3	40		ANESTHESIOLOGY	250,008	250,008					
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
101			TOTAL	1,136,002	451,741	684,261				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1344 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10		COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	50	1	CARDIAC REHAB							370
2	61		EMERGENCY							201,363
3	40		ANESTHESIOLOGY							250,008
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
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20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
101			TOTAL							451,741

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

I PROVIDER NO: 14-1344 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	365
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		14.00			
10	AHSEA (SEE INSTRUCTIONS)		70.65			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	35.33	35.33			
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)	989
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)	989
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)	989

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	70.64
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	55,099
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	55,099

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)	12,895
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	12,895
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	12,895

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

PHYSICAL THERAPY

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)	12,895
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)	55,099

58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	12,895
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)	67,994
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	810
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)	810
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)	810
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: 14-1344 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-4 I PARTS I - VII

RESPIRATORY THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	365
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED	44.00	81.00			
10	AHSEA (SEE INSTRUCTIONS)	65.93	52.43			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	26.22	26.22			
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)	2,901
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	4,247
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	7,148
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	7,148

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)	57.18
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	44,600
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	44,600

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)	9,570
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	9,570
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	9,570

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

RESPIRATORY THERAPY

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)	9,570
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)	44,600

58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	9,570
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)	54,170
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	3,615
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)	3,615
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)	3,615
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO: I 14-1344 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET A-8-4 I PARTS I - VII

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	365
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		134.00			
10	AHSEA (SEE INSTRUCTIONS)		64.37			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.19	32.19			
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	8,626
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	8,626
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)	8,626

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)	64.37
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	50,209
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	50,209

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)	11,749
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	11,749
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	11,749

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

SPEECH PATHOLOGY

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)	11,749
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)	50,209

SPEECH PATHOLOGY

58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	11,749
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)	61,958
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	9,860
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)	9,860
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)	9,860
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

COST ALLOCATION STATISTICS

I PROVIDER NO: I 14-1344 I
I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I
I PREPARED 11/23/2010 I NOT A CMS WORKSHEET I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS SALARIES	NOT ENTERED
6.01	ADMINISTRATIVE & GENERAL	C	GROSS CHARGES	NOT ENTERED
6.02	PURCHASING, RECEIVING AND STORES	14	COSTED REQUIS.	ENTERED
6.03	COMMUNICATIONS	17	TIME SPENT	ENTERED
6.04	OTHER ADMINISTRATIVE AND GENERAL	#	ACCUM. COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	3	SQUARE FEET	ENTERED
8	OPERATION OF PLANT	3	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF SERVICE	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	6	FTE'S	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	ENTERED
16	PHARMACY	15	COSTED REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	ENTERED
18	SOCIAL SERVICE	19	TIME SPENT	ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED TIME	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET B | PART I

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	PURCHASING, RECEIVING AND	COMMUNICATIONS
			0	3	4	5	6.01	6.02	6.03
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	278,503	278,503					
004		NEW CAP REL COSTS-MVBLE E	337,219		337,219				
005		EMPLOYEE BENEFITS	1,774,401			1,774,401			
006	01	ADMINISTRATIVE & GENERAL	533,781	4,599	3,025	113,588	654,993		
006	02	PURCHASING, RECEIVING AND	65,325	4,745		23,286		93,356	
006	03	COMMUNICATIONS	48,064						48,064
006	04	OTHER ADMINISTRATIVE AND	924,779	26,076	9,701	61,528		4,695	4,272
007		MAINTENANCE & REPAIRS	247,259			55,575		4,372	
008		OPERATION OF PLANT	116,040	67,207	8,449				2,848
009		LAUNDRY & LINEN SERVICE	45,295						
010		HOUSEKEEPING	196,077	3,591		67,494		3,955	356
011		DIETARY	88,331	4,215	594	19,171		1,251	1,424
012		CAFETERIA	186,320	9,265	1,783	56,526		3,753	
014		NURSING ADMINISTRATION	164,200	1,459		50,028		4,872	1,068
015		CENTRAL SERVICES & SUPPLY							
016		PHARMACY	175,783	1,867		62,200			
017		MEDICAL RECORDS & LIBRARY	230,653	6,209	2,883	69,384		529	4,628
018		SOCIAL SERVICE	55,104	506		20,759		157	712
020		NONPHYSICIAN ANESTHETISTS	10,422						
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	831,111	28,488	8,498	312,313	44,673	6,615	9,259
031		SUBPROVIDER							
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	310,439	24,035	30,085	65,650	43,056	13,312	3,204
040		ANESTHESIOLOGY	28,393	538	3,925	1,755	7,734	1,420	356
041		RADIOLOGY-DIAGNOSTIC	883,715	8,360	138,402	81,104	145,567	9,257	2,136
044		LABORATORY	779,995	4,338	4,472	146,607	138,234	9,153	1,780
046		WHOLE BLOOD & PACKED RED	67,493	395			8,914	127	
049		RESPIRATORY THERAPY	164,881	3,547	744	56,864	18,018	1,205	1,780
050		PHYSICAL THERAPY	121,258	4,670	552	42,626	9,651	447	1,068
050	01	CARDIAC REHAB	14,185	1,898	11,967	5,422	1,244	68	356
053		ELECTROCARDIOLOGY							
055		MEDICAL SUPPLIES CHARGED	37,571				23,144	8,353	
056		DRUGS CHARGED TO PATIENTS	146,166		125		46,404	1,442	712
059		OTHER ANCILLARY SERVICE C	43,857			14,114	641	140	
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	70,443	9,772	17,308	21,238	1,179	655	2,136
061		EMERGENCY	1,053,536	9,420	5,989	127,854	98,846	6,899	2,492
062		OBSERVATION BEDS (NON-DIS							
063		FAMILY PRACTICE							
063	50	RURAL HEALTH CLINIC	815,549	30,628	49,729	140,791	37,771	3,886	6,053
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	468,664		7,520	157,890	29,917	6,205	1,424
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	11,314,812	255,828	305,751	1,773,767	654,993	92,768	48,064
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC	16,398	22,675	31,468	634		588	
098	01	RURAL HEALTH CLINC (NON-C							
098	02	LSC							
098	03	PUBLIC RELATIONS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	11,331,210	278,503	337,219	1,774,401	654,993	93,356	48,064

		COST CENTER DESCRIPTION	SUBTOTAL	OTHER ADMINIS TRATIVE AND	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY
			6a.03	6.04	7	8	9	10	11
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006	01	ADMINISTRATIVE & GENERAL							
006	02	PURCHASING, RECEIVING AND							
006	03	COMMUNICATIONS							
006	04	OTHER ADMINISTRATIVE AND	1,031,051	1,031,051					
007		MAINTENANCE & REPAIRS	307,206	30,751	337,957				
008		OPERATION OF PLANT	194,544	19,474	93,436	307,454			
009		LAUNDRY & LINEN SERVICE	45,295	4,534			49,829		
010		HOUSEKEEPING	271,473	27,174	4,992	6,277		309,916	
011		DIETARY	114,986	11,510	5,861	7,369	177	11,115	151,018
012		CAFETERIA	257,647	25,790	12,882	16,197		33,346	
014		NURSING ADMINISTRATION	221,627	22,185	2,029	2,551		439	
015		CENTRAL SERVICES & SUPPLY							
016		PHARMACY	239,850	24,009	2,595	3,263		304	
017		MEDICAL RECORDS & LIBRARY	314,286	31,460	8,632	10,853		6,250	
018		SOCIAL SERVICE	77,238	7,732	704	885			
020		NONPHYSICIAN ANESTHETISTS	10,422	1,043					
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,240,957	124,220	39,607	49,801	30,408	72,877	151,018
031		SUBPROVIDER							
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	489,781	49,027	33,416	42,017	5,053	30,677	
040		ANESTHESIOLOGY	44,121	4,417	748	940			
041		RADIOLOGY-DIAGNOSTIC	1,268,541	126,981	11,623	14,614	3,239	12,839	
044		LABORATORY	1,084,579	108,566	6,031	7,584		15,372	
046		WHOLE BLOOD & PACKED RED	76,929	7,701	550	691			
049		RESPIRATORY THERAPY	247,039	24,729	4,932	6,201	294	4,798	
050		PHYSICAL THERAPY	180,272	18,045	6,493	8,164	1,651	5,000	
050	01	CARDIAC REHAB	35,140	3,518	2,639	3,318		3,716	
053		ELECTROCARDIOLOGY							
055		MEDICAL SUPPLIES CHARGED	69,068	6,914					
056		DRUGS CHARGED TO PATIENTS	194,849	19,504					
059		OTHER ANCILLARY SERVICE C	58,752	5,881					
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	122,731	12,285	13,585	17,082	53	10,034	
061		EMERGENCY	1,305,036	130,640	13,096	16,467	7,811	29,867	
062		OBSERVATION BEDS (NON-DIS							
063		FAMILY PRACTICE							
063	50	RURAL HEALTH CLINIC	1,084,407	108,549	42,581	53,541		34,597	
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	671,620	67,229			1,143	338	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	11,259,447	1,023,868	306,432	267,815	49,829	271,569	151,018
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC	71,763	7,183	31,525	39,639		38,347	
098	01	RURAL HEALTH CLINC (NON-C							
098	02	LSC							
098	03	PUBLIC RELATIONS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	11,331,210	1,031,051	337,957	307,454	49,829	309,916	151,018

		COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS
			12	14	15	16	17	18	20
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006	01	ADMINISTRATIVE & GENERAL							
006	02	PURCHASING, RECEIVING AND							
006	03	COMMUNICATIONS							
006	04	OTHER ADMINISTRATIVE AND							
007		MAINTENANCE & REPAIRS							
008		OPERATION OF PLANT							
009		LAUNDRY & LINEN SERVICE							
010		HOUSEKEEPING							
011		DIETARY							
012		CAFETERIA	345,862						
014		NURSING ADMINISTRATION	7,438	256,269					
015		CENTRAL SERVICES & SUPPLY							
016		PHARMACY				270,021			
017		MEDICAL RECORDS & LIBRARY	26,033				397,514		
018		SOCIAL SERVICE	3,719					90,278	
020		NONPHYSICIAN ANESTHETISTS							11,465
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	81,816	158,415			145,640	90,278	
031		SUBPROVIDER							
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	14,876	26,938			47,127		
040		ANESTHESIOLOGY							
041		RADIOLOGY-DIAGNOSTIC	18,595						11,465
044		LABORATORY	37,189						
046		WHOLE BLOOD & PACKED RED							
049		RESPIRATORY THERAPY	11,157				18,105		
050		PHYSICAL THERAPY	7,438	12,277					
050	01	CARDIAC REHAB	3,719						
053		ELECTROCARDIOLOGY							
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS	7,438			270,021			
059		OTHER ANCILLARY SERVICE C							
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	7,438						
061		EMERGENCY	29,752	58,639			186,642		
062		OBSERVATION BEDS (NON-DIS							
063		FAMILY PRACTICE							
063	50	RURAL HEALTH CLINIC	37,189						
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	48,346						
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	342,143	256,269		270,021	397,514	90,278	11,465
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC	3,719						
098	01	RURAL HEALTH CLINC (NON-C							
098	02	LSC							
098	03	PUBLIC RELATIONS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	345,862	256,269		270,021	397,514	90,278	11,465

COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET B | PART I

		COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
			25	26	27
		GENERAL SERVICE COST CNTR			
003		NEW CAP REL COSTS-BLDG &			
004		NEW CAP REL COSTS-MVBLE E			
005		EMPLOYEE BENEFITS			
006	01	ADMINISTRATIVE & GENERAL			
006	02	PURCHASING, RECEIVING AND			
006	03	COMMUNICATIONS			
006	04	OTHER ADMINISTRATIVE AND			
007		MAINTENANCE & REPAIRS			
008		OPERATION OF PLANT			
009		LAUNDRY & LINEN SERVICE			
010		HOUSEKEEPING			
011		DIETARY			
012		CAFETERIA			
014		NURSING ADMINISTRATION			
015		CENTRAL SERVICES & SUPPLY			
016		PHARMACY			
017		MEDICAL RECORDS & LIBRARY			
018		SOCIAL SERVICE			
020		NONPHYSICIAN ANESTHETISTS			
		INPAT ROUTINE SRVC CNTRS			
025		ADULTS & PEDIATRICS	2,185,037		2,185,037
031		SUBPROVIDER			
		ANCILLARY SRVC COST CNTRS			
037		OPERATING ROOM	738,912		738,912
040		ANESTHESIOLOGY	50,226		50,226
041		RADIOLOGY-DIAGNOSTIC	1,467,897		1,467,897
044		LABORATORY	1,259,321		1,259,321
046		WHOLE BLOOD & PACKED RED	85,871		85,871
049		RESPIRATORY THERAPY	317,255		317,255
050		PHYSICAL THERAPY	239,340		239,340
050	01	CARDIAC REHAB	52,050		52,050
053		ELECTROCARDIOLOGY			
055		MEDICAL SUPPLIES CHARGED	75,982		75,982
056		DRUGS CHARGED TO PATIENTS	491,812		491,812
059		OTHER ANCILLARY SERVICE C	64,633		64,633
		OUTPAT SERVICE COST CNTRS			
060		CLINIC	183,208		183,208
061		EMERGENCY	1,777,950		1,777,950
062		OBSERVATION BEDS (NON-DIS			
063		FAMILY PRACTICE			
063	50	RURAL HEALTH CLINIC	1,360,864		1,360,864
		OTHER REIMBURS COST CNTRS			
065		AMBULANCE SERVICES	788,676		788,676
		SPEC PURPOSE COST CENTERS			
095		SUBTOTALS	11,139,034		11,139,034
		NONREIMBURS COST CENTERS			
096		GIFT, FLOWER, COFFEE SHOP			
098		PHYSICIANS' PRIVATE OFFIC	192,176		192,176
098	01	RURAL HEALTH CLINC (NON-C			
098	02	LSC			
098	03	PUBLIC RELATIONS			
100		OTHER NONREIMBURSABLE COS			
101		CROSS FOOT ADJUSTMENT			
102		NEGATIVE COST CENTER			
103		TOTAL	11,331,210		11,331,210

ALLOCATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET B PART III

		COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	PURCHASING, RECEIVING AND
			0	3	4	4a	5	6.01	6.02
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006	01	ADMINISTRATIVE & GENERAL		4,599	3,025	7,624		7,624	
006	02	PURCHASING, RECEIVING AND		4,745		4,745			4,745
006	03	COMMUNICATIONS							
006	04	OTHER ADMINISTRATIVE AND		26,076	9,701	35,777			239
007		MAINTENANCE & REPAIRS							222
008		OPERATION OF PLANT		67,207	8,449	75,656			
009		LAUNDRY & LINEN SERVICE							
010		HOUSEKEEPING		3,591		3,591			201
011		DIETARY		4,215	594	4,809			64
012		CAFETERIA		9,265	1,783	11,048			191
014		NURSING ADMINISTRATION		1,459		1,459			248
015		CENTRAL SERVICES & SUPPLY							
016		PHARMACY		1,867		1,867			
017		MEDICAL RECORDS & LIBRARY		6,209	2,883	9,092			27
018		SOCIAL SERVICE		506		506			8
020		NONPHYSICIAN ANESTHETISTS							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS		28,488	8,498	36,986		520	336
031		SUBPROVIDER							
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM		24,035	30,085	54,120		501	676
040		ANESTHESIOLOGY		538	3,925	4,463		90	72
041		RADIOLOGY-DIAGNOSTIC		8,360	138,402	146,762		1,696	471
044		LABORATORY		4,338	4,472	8,810		1,609	465
046		WHOLE BLOOD & PACKED RED		395		395		104	6
049		RESPIRATORY THERAPY		3,547	744	4,291		210	61
050		PHYSICAL THERAPY		4,670	552	5,222		112	23
050	01	CARDIAC REHAB		1,898	11,967	13,865		14	3
053		ELECTROCARDIOLOGY							
055		MEDICAL SUPPLIES CHARGED						269	425
056		DRUGS CHARGED TO PATIENTS			125	125		540	73
059		OTHER ANCILLARY SERVICE C						7	7
		OUTPAT SERVICE COST CNTRS							
060		CLINIC		9,772	17,308	27,080		14	33
061		EMERGENCY		9,420	5,989	15,409		1,150	351
062		OBSERVATION BEDS (NON-DIS							
063		FAMILY PRACTICE							
063	50	RURAL HEALTH CLINIC		30,628	49,729	80,357		440	198
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES			7,520	7,520		348	315
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS		255,828	305,751	561,579		7,624	4,715
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC		22,675	31,468	54,143			30
098	01	RURAL HEALTH CLINC (NON-C							
098	02	LSC							
098	03	PUBLIC RELATIONS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL		278,503	337,219	615,722		7,624	4,745

		COST CENTER DESCRIPTION	COMMUNICATIONS 6.03	OTHER ADMINISTRATIVE AND 6.04	MAINTENANCE & REPAIRS 7	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006	01	ADMINISTRATIVE & GENERAL							
006	02	PURCHASING, RECEIVING AND							
006	03	COMMUNICATIONS							
006	04	OTHER ADMINISTRATIVE AND		36,016					
007		MAINTENANCE & REPAIRS		1,074	1,296				
008		OPERATION OF PLANT		680	359	76,695			
009		LAUNDRY & LINEN SERVICE		158			158		
010		HOUSEKEEPING		949	19	1,566		6,326	
011		DIETARY		402	22	1,838	1	227	7,363
012		CAFETERIA		901	49	4,040		681	
014		NURSING ADMINISTRATION		775	8	636		9	
015		CENTRAL SERVICES & SUPPLY							
016		PHARMACY		839	10	814		6	
017		MEDICAL RECORDS & LIBRARY		1,099	33	2,707		128	
018		SOCIAL SERVICE		270	3	221			
020		NONPHYSICIAN ANESTHETISTS		36					
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS		4,340	152	12,423	96	1,486	7,363
031		SUBPROVIDER							
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM		1,713	128	10,481	16	626	
040		ANESTHESIOLOGY		154	3	235			
041		RADIOLOGY-DIAGNOSTIC		4,436	45	3,645	10	262	
044		LABORATORY		3,793	23	1,892		314	
046		WHOLE BLOOD & PACKED RED		269	2	172			
049		RESPIRATORY THERAPY		864	19	1,547	1	98	
050		PHYSICAL THERAPY		630	25	2,037	5	102	
050	01	CARDIAC REHAB		123	10	828		76	
053		ELECTROCARDIOLOGY							
055		MEDICAL SUPPLIES CHARGED		242					
056		DRUGS CHARGED TO PATIENTS		681					
059		OTHER ANCILLARY SERVICE C		205					
		OUTPAT SERVICE COST CNTRS							
060		CLINIC		429	52	4,261		205	
061		EMERGENCY		4,562	50	4,108	25	610	
062		OBSERVATION BEDS (NON-DIS							
063		FAMILY PRACTICE							
063	50	RURAL HEALTH CLINIC		3,792	163	13,356		706	
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES		2,349			4	7	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS		35,765	1,175	66,807	158	5,543	7,363
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC		251	121	9,888		783	
098	01	RURAL HEALTH CLINC (NON-C							
098	02	LSC							
098	03	PUBLIC RELATIONS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL		36,016	1,296	76,695	158	6,326	7,363

		COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS
			12	14	15	16	17	18	20
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006	01	ADMINISTRATIVE & GENERAL							
006	02	PURCHASING, RECEIVING AND							
006	03	COMMUNICATIONS							
006	04	OTHER ADMINISTRATIVE AND							
007		MAINTENANCE & REPAIRS							
008		OPERATION OF PLANT							
009		LAUNDRY & LINEN SERVICE							
010		HOUSEKEEPING							
011		DIETARY							
012		CAFETERIA	16,910						
014		NURSING ADMINISTRATION	364	3,499					
015		CENTRAL SERVICES & SUPPLY							
016		PHARMACY				3,536			
017		MEDICAL RECORDS & LIBRARY	1,273				14,359		
018		SOCIAL SERVICE	182					1,190	
020		NONPHYSICIAN ANESTHETISTS							36
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	3,999	2,162			5,261	1,190	
031		SUBPROVIDER							
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	727	368			1,702		
040		ANESTHESIOLOGY							
041		RADIOLOGY-DIAGNOSTIC	909						
044		LABORATORY	1,818						
046		WHOLE BLOOD & PACKED RED							
049		RESPIRATORY THERAPY	545				654		
050		PHYSICAL THERAPY	364	168					
050	01	CARDIAC REHAB	182						
053		ELECTROCARDIOLOGY							
055		MEDICAL SUPPLIES CHARGED							
056		DRUGS CHARGED TO PATIENTS	364			3,536			
059		OTHER ANCILLARY SERVICE C							
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	364						
061		EMERGENCY	1,455	801			6,742		
062		OBSERVATION BEDS (NON-DIS							
063		FAMILY PRACTICE							
063	50	RURAL HEALTH CLINIC	1,818						
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	2,364						
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	16,728	3,499		3,536	14,359	1,190	
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
098		PHYSICIANS' PRIVATE OFFIC	182						
098	01	RURAL HEALTH CLINC (NON-C							
098	02	LSC							
098	03	PUBLIC RELATIONS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENTS							36
102		NEGATIVE COST CENTER							
103		TOTAL	16,910	3,499		3,536	14,359	1,190	36

ALLOCATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET B | PART III

		COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
			25	26	27
		GENERAL SERVICE COST CNTR			
003		NEW CAP REL COSTS-BLDG &			
004		NEW CAP REL COSTS-MVBLE E			
005		EMPLOYEE BENEFITS			
006	01	ADMINISTRATIVE & GENERAL			
006	02	PURCHASING, RECEIVING AND			
006	03	COMMUNICATIONS			
006	04	OTHER ADMINISTRATIVE AND			
007		MAINTENANCE & REPAIRS			
008		OPERATION OF PLANT			
009		LAUNDRY & LINEN SERVICE			
010		HOUSEKEEPING			
011		DIETARY			
012		CAFETERIA			
014		NURSING ADMINISTRATION			
015		CENTRAL SERVICES & SUPPLY			
016		PHARMACY			
017		MEDICAL RECORDS & LIBRARY			
018		SOCIAL SERVICE			
020		NONPHYSICIAN ANESTHETISTS			
		INPAT ROUTINE SRVC CNTRS			
025		ADULTS & PEDIATRICS	76,314		76,314
031		SUBPROVIDER			
		ANCILLARY SRVC COST CNTRS			
037		OPERATING ROOM	71,058		71,058
040		ANESTHESIOLOGY	5,017		5,017
041		RADIOLOGY-DIAGNOSTIC	158,236		158,236
044		LABORATORY	18,724		18,724
046		WHOLE BLOOD & PACKED RED	948		948
049		RESPIRATORY THERAPY	8,290		8,290
050		PHYSICAL THERAPY	8,688		8,688
050	01	CARDIAC REHAB	15,101		15,101
053		ELECTROCARDIOLOGY			
055		MEDICAL SUPPLIES CHARGED	936		936
056		DRUGS CHARGED TO PATIENTS	5,319		5,319
059		OTHER ANCILLARY SERVICE C	219		219
		OUTPAT SERVICE COST CNTRS			
060		CLINIC	32,438		32,438
061		EMERGENCY	35,263		35,263
062		OBSERVATION BEDS (NON-DIS			
063		FAMILY PRACTICE			
063	50	RURAL HEALTH CLINIC	100,830		100,830
		OTHER REIMBURS COST CNTRS			
065		AMBULANCE SERVICES	12,907		12,907
		SPEC PURPOSE COST CENTERS			
095		SUBTOTALS	550,288		550,288
		NONREIMBURS COST CENTERS			
096		GIFT, FLOWER, COFFEE SHOP			
098		PHYSICIANS' PRIVATE OFFIC	65,398		65,398
098	01	RURAL HEALTH CLINC (NON-C			
098	02	LSC			
098	03	PUBLIC RELATIONS			
100		OTHER NONREIMBURSABLE COS			
101		CROSS FOOT ADJUSTMENTS	36		36
102		NEGATIVE COST CENTER			
103		TOTAL	615,722		615,722

COST ALLOCATION - STATISTICAL BASIS | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (GROSS CHARGES)	PURCHASING, RECEIVING (COSTED EQUIS.)	COMMUNICATIONS (TIME SPENT)
		3	4	5	6.01	6.02	6.03
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	70,427					
004	NEW CAP REL COSTS-MVB		395,170				
005	EMPLOYEE BENEFITS			4,449,732			
006 01	ADMINISTRATIVE & GENE	1,163	3,545	284,850	22,821,935		
006 02	PURCHASING, RECEIVING	1,200		58,396		625,935	
006 03	COMMUNICATIONS						135
006 04	OTHER ADMINISTRATIVE	6,594	11,368	154,297		31,479	12
007	MAINTENANCE & REPAIRS			139,367		29,311	
008	OPERATION OF PLANT	16,995	9,901				8
009	LAUNDRY & LINEN SERVI						
010	HOUSEKEEPING	908		169,257		26,516	1
011	DIETARY	1,066	696	48,076		8,388	4
012	CAFETERIA	2,343	2,089	141,753		25,164	
014	NURSING ADMINISTRATIO	369		125,457		32,664	3
015	CENTRAL SERVICES & SU						
016	PHARMACY	472		155,982			
017	MEDICAL RECORDS & LIB	1,570	3,378	173,996		3,548	13
018	SOCIAL SERVICE	128		52,059		1,052	2
020	NONPHYSICIAN ANESTHET						
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	7,204	9,958	783,197	1,556,555	44,351	26
031	SUBPROVIDER						
	ANCILLARY SRVC COST C						
037	OPERATING ROOM	6,078	35,255	164,632	1,500,204	89,244	9
040	ANESTHESIOLOGY	136	4,599	4,400	269,475	9,518	1
041	RADIOLOGY-DIAGNOSTIC	2,114	162,188	203,388	5,071,845	62,068	6
044	LABORATORY	1,097	5,241	367,651	4,816,505	61,371	5
046	WHOLE BLOOD & PACKED	100			310,609	853	
049	RESPIRATORY THERAPY	897	872	142,600	627,807	8,080	5
050	PHYSICAL THERAPY	1,181	647	106,896	336,275	2,999	3
050 01	CARDIAC REHAB	480	14,024	13,597	43,350	456	1
053	ELECTROCARDIOLOGY						
055	MEDICAL SUPPLIES CHAR				806,421	56,007	
056	DRUGS CHARGED TO PATI		146		1,616,880	9,668	2
059	OTHER ANCILLARY SERVI			35,393	22,326	941	
	OUTPAT SERVICE COST C						
060	CLINIC	2,471	20,282	53,260	41,074	4,393	6
061	EMERGENCY	2,382	7,018	320,625	3,444,124	46,259	7
062	OBSERVATION BEDS (NON						
063	FAMILY PRACTICE						
063 50	RURAL HEALTH CLINIC	7,745	58,275	353,067	1,316,071	26,055	17
	OTHER REIMBURS COST C						
065	AMBULANCE SERVICES		8,812	395,947	1,042,414	41,606	4
	SPEC PURPOSE COST CEN						
095	SUBTOTALS	64,693	358,294	4,448,143	22,821,935	621,991	135
	NONREIMBURS COST CENT						
096	GIFT, FLOWER, COFFEE						
098	PHYSICIANS' PRIVATE O	5,734	36,876	1,589		3,944	
098 01	RURAL HEALTH CLINC (N						
098 02	LSC						
098 03	PUBLIC RELATIONS						
100	OTHER NONREIMBURSABLE						
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	278,503	337,219	1,774,401	654,993	93,356	48,064
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	3.954492	.853352	.398766	.028700	.149146	356.029630
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				7,624	4,745	
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)				.000334	.007581	

	COST CENTER DESCRIPTION	RECONCIL-IATION	(ACCUM. COST)	OTHER ADMINISTRATIVE AND (SQUARE FEET)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (POUNDS OF LAUNDRY)	LAUNDRY & LINEN SERVICE (HOURS OF SERVICE)	HOUSEKEEPING (MEALS SERVED)	DIETARY
		6a.04	6.04	7	8	9	10	11	
	GENERAL SERVICE COST								
003	NEW CAP REL COSTS-BLD								
004	NEW CAP REL COSTS-MVB								
005	EMPLOYEE BENEFITS								
006 01	ADMINISTRATIVE & GENE								
006 02	PURCHASING, RECEIVING								
006 03	COMMUNICATIONS								
006 04	OTHER ADMINISTRATIVE	-1,031,051	10,300,159						
007	MAINTENANCE & REPAIRS		307,206	61,470					
008	OPERATION OF PLANT		194,544	16,995	44,475				
009	LAUNDRY & LINEN SERVI		45,295			68,562			
010	HOUSEKEEPING		271,473	908	908		9,173		
011	DIETARY		114,986	1,066	1,066	244	329	2,376	
012	CAFETERIA		257,647	2,343	2,343		987		
014	NURSING ADMINISTRATIO		221,627	369	369		13		
015	CENTRAL SERVICES & SU								
016	PHARMACY		239,850	472	472		9		
017	MEDICAL RECORDS & LIB		314,286	1,570	1,570		185		
018	SOCIAL SERVICE		77,238	128	128				
020	NONPHYSICIAN ANESTHET		10,422						
	INPAT ROUTINE SRVC CN								
025	ADULTS & PEDIATRICS		1,240,957	7,204	7,204	41,840	2,157	2,376	
031	SUBPROVIDER								
	ANCILLARY SRVC COST C								
037	OPERATING ROOM		489,781	6,078	6,078	6,952	908		
040	ANESTHESIOLOGY		44,121	136	136				
041	RADIOLOGY-DIAGNOSTIC		1,268,541	2,114	2,114	4,456	380		
044	LABORATORY		1,084,579	1,097	1,097		455		
046	WHOLE BLOOD & PACKED		76,929	100	100				
049	RESPIRATORY THERAPY		247,039	897	897	405	142		
050	PHYSICAL THERAPY		180,272	1,181	1,181	2,271	148		
050 01	CARDIAC REHAB		35,140	480	480		110		
053	ELECTROCARDIOLOGY								
055	MEDICAL SUPPLIES CHAR		69,068						
056	DRUGS CHARGED TO PATI		194,849						
059	OTHER ANCILLARY SERVI		58,752						
	OUTPAT SERVICE COST C								
060	CLINIC		122,731	2,471	2,471	73	297		
061	EMERGENCY		1,305,036	2,382	2,382	10,748	884		
062	OBSERVATION BEDS (NON								
063	FAMILY PRACTICE								
063 50	RURAL HEALTH CLINIC		1,084,407	7,745	7,745		1,024		
	OTHER REIMBURS COST C								
065	AMBULANCE SERVICES		671,620			1,573	10		
	SPEC PURPOSE COST CEN								
095	SUBTOTALS	-1,031,051	10,228,396	55,736	38,741	68,562	8,038	2,376	
	NONREIMBURS COST CENT								
096	GIFT, FLOWER, COFFEE								
098	PHYSICIANS' PRIVATE O		71,763	5,734	5,734		1,135		
098 01	RURAL HEALTH CLINC (N								
098 02	LSC								
098 03	PUBLIC RELATIONS								
100	OTHER NONREIMBURSABLE								
101	CROSS FOOT ADJUSTMENT								
102	NEGATIVE COST CENTER								
103	COST TO BE ALLOCATED (WRKSHT B, PART I)		1,031,051	337,957	307,454	49,829	309,916	151,018	
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)		.100100	5.497918	6.912962	.726773	33.785675	63.559764	
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		36,016	1,296	76,695	158	6,326	7,363	
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)		.003497	.021083	1.724452	.002304	.689633	3.098906	

	COST CENTER DESCRIPTION	CAFETERIA (FTE'S	NURSING ADMINISTRATION (DIRECTSING HRS	CENTRAL SERVICES & SUPPLY NR(COSTEDEQUIS.	PHARMACY R(COSTEDEQUIS.	MEDICAL RECORDS & LIBRARY R(TIMESPENT	SOCIAL SERVICE (TIMESPENT	NONPHYSICIAN ANESTHETISTS (ASSIGNEDTIME)
		12	14	15	16	17	18	20
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006 01	ADMINISTRATIVE & GENE							
006 02	PURCHASING, RECEIVING							
006 03	COMMUNICATIONS							
006 04	OTHER ADMINISTRATIVE							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVI							
010	HOUSEKEEPING							
011	DIETARY							
012	CAFETERIA	93						
014	NURSING ADMINISTRATIO	2	72,957					
015	CENTRAL SERVICES & SU			472,413				
016	PHARMACY				100			
017	MEDICAL RECORDS & LIB	7		3,548		1,493		
018	SOCIAL SERVICE	1		1,052			100	
020	NONPHYSICIAN ANESTHET							100
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	22	45,099	44,351		547	100	
031	SUBPROVIDER							
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	4	7,669	89,244		177		
040	ANESTHESIOLOGY			9,518				
041	RADIOLOGY-DIAGNOSTIC	5		62,068				100
044	LABORATORY	10		61,371				
046	WHOLE BLOOD & PACKED			853				
049	RESPIRATORY THERAPY	3		8,080		68		
050	PHYSICAL THERAPY	2	3,495	2,999				
050 01	CARDIAC REHAB	1		456				
053	ELECTROCARDIOLOGY							
055	MEDICAL SUPPLIES CHAR			56,007				
056	DRUGS CHARGED TO PATI	2		9,668	100			
059	OTHER ANCILLARY SERVI			941				
	OUTPAT SERVICE COST C							
060	CLINIC	2		4,393				
061	EMERGENCY	8	16,694	46,259		701		
062	OBSERVATION BEDS (NON							
063	FAMILY PRACTICE							
063 50	RURAL HEALTH CLINIC	10		26,055				
	OTHER REIMBURS COST C							
065	AMBULANCE SERVICES	13		41,606				
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	92	72,957	468,469	100	1,493	100	100
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE							
098	PHYSICIANS' PRIVATE O	1		3,944				
098 01	RURAL HEALTH CLINC (N							
098 02	LSC							
098 03	PUBLIC RELATIONS							
100	OTHER NONREIMBURSABLE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	345,862	256,269		270,021	397,514	90,278	11,465
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	3,718.946237	3.512603		2,700.210000	266.251842	902.780000	114.650000
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	16,910	3,499		3,536	14,359	1,190	36
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	181.827957	.047960		35.360000	9.617549	11.900000	.360000

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | 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	2,185,037		2,185,037		
31	SUBPROVIDER					
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	738,912		738,912		
40	ANESTHESIOLOGY	50,226		50,226		
41	RADIOLOGY-DIAGNOSTIC	1,467,897		1,467,897		
44	LABORATORY	1,259,321		1,259,321		
46	WHOLE BLOOD & PACKED RED	85,871		85,871		
49	RESPIRATORY THERAPY	317,255		317,255		
50	PHYSICAL THERAPY	239,340		239,340		
50 01	CARDIAC REHAB	52,050		52,050		
53	ELECTROCARDIOLOGY					
55	MEDICAL SUPPLIES CHARGED	75,982		75,982		
56	DRUGS CHARGED TO PATIENTS	491,812		491,812		
59	OTHER ANCILLARY SERVICE C	64,633		64,633		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	183,208		183,208		
61	EMERGENCY	1,777,950		1,777,950		
62	OBSERVATION BEDS (NON-DIS	9,703		9,703		
63	FAMILY PRACTICE					
63 50	RURAL HEALTH CLINIC	1,360,864		1,360,864		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	788,676		788,676		
101	SUBTOTAL	11,148,737		11,148,737		
102	LESS OBSERVATION BEDS	9,703		9,703		
103	TOTAL	11,139,034		11,139,034		

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET C | PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES	OUTPATIENT CHARGES	TOTAL CHARGES	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO
			6	7	8	9	10	11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	1,546,027		1,546,027			
31		SUBPROVIDER						
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	156,115	1,344,089	1,500,204	.492541	.492541	
40		ANESTHESIOLOGY	68,975	200,500	269,475	.186385	.186385	
41		RADIOLOGY-DIAGNOSTIC	648,384	4,423,461	5,071,845	.289421	.289421	
44		LABORATORY	772,982	4,043,523	4,816,505	.261460	.261460	
46		WHOLE BLOOD & PACKED RED	256,151	54,458	310,609	.276460	.276460	
49		RESPIRATORY THERAPY	412,393	215,414	627,807	.505338	.505338	
50		PHYSICAL THERAPY	82,672	253,603	336,275	.711739	.711739	
50	01	CARDIAC REHAB		43,350	43,350	1.200692	1.200692	
53		ELECTROCARDIOLOGY						
55		MEDICAL SUPPLIES CHARGED	716,421	90,000	806,421	.094221	.094221	
56		DRUGS CHARGED TO PATIENTS	1,145,347	471,533	1,616,880	.304173	.304173	
59		OTHER ANCILLARY SERVICE C		22,326	22,326	2.894966	2.894966	
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	20,000	21,074	41,074	4.460437	4.460437	
61		EMERGENCY	110,648	3,333,476	3,444,124	.516227	.516227	
62		OBSERVATION BEDS (NON-DIS	849	9,679	10,528	.921638	.921638	
63		FAMILY PRACTICE						
63	50	RURAL HEALTH CLINIC	136,329	1,179,742	1,316,071	1.034035	1.034035	
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES		1,042,414	1,042,414	.756586	.756586	
101		SUBTOTAL	6,073,293	16,748,642	22,821,935			
102		LESS OBSERVATION BEDS						
103		TOTAL	6,073,293	16,748,642	22,821,935			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 14-1344
PERIOD: FROM 7/ 1/2009 TO 6/30/2010

PREPARED 11/23/2010
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	2,185,037		2,185,037		
31	SUBPROVIDER					
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	738,912		738,912		
40	ANESTHESIOLOGY	50,226		50,226		
41	RADIOLOGY-DIAGNOSTIC	1,467,897		1,467,897		
44	LABORATORY	1,259,321		1,259,321		
46	WHOLE BLOOD & PACKED RED	85,871		85,871		
49	RESPIRATORY THERAPY	317,255		317,255		
50	PHYSICAL THERAPY	239,340		239,340		
50 01	CARDIAC REHAB	52,050		52,050		
53	ELECTROCARDIOLOGY					
55	MEDICAL SUPPLIES CHARGED	75,982		75,982		
56	DRUGS CHARGED TO PATIENTS	491,812		491,812		
59	OTHER ANCILLARY SERVICE C	64,633		64,633		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	183,208		183,208		
61	EMERGENCY	1,777,950		1,777,950		
62	OBSERVATION BEDS (NON-DIS	9,703		9,703		
63	FAMILY PRACTICE					
63 50	RURAL HEALTH CLINIC	1,360,864		1,360,864		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	788,676		788,676		
101	SUBTOTAL	11,148,737		11,148,737		
102	LESS OBSERVATION BEDS	9,703		9,703		
103	TOTAL	11,139,034		11,139,034		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

PROVIDER NO: 14-1344
PERIOD: FROM 7/ 1/2009 TO 6/30/2010

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	1,546,027		1,546,027			
31		SUBPROVIDER						
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	156,115	1,344,089	1,500,204	.492541	.492541	
40		ANESTHESIOLOGY	68,975	200,500	269,475	.186385	.186385	
41		RADIOLOGY-DIAGNOSTIC	648,384	4,423,461	5,071,845	.289421	.289421	
44		LABORATORY	772,982	4,043,523	4,816,505	.261460	.261460	
46		WHOLE BLOOD & PACKED RED	256,151	54,458	310,609	.276460	.276460	
49		RESPIRATORY THERAPY	412,393	215,414	627,807	.505338	.505338	
50		PHYSICAL THERAPY	82,672	253,603	336,275	.711739	.711739	
50	01	CARDIAC REHAB		43,350	43,350	1.200692	1.200692	
53		ELECTROCARDIOLOGY						
55		MEDICAL SUPPLIES CHARGED	716,421	90,000	806,421	.094221	.094221	
56		DRUGS CHARGED TO PATIENTS	1,145,347	471,533	1,616,880	.304173	.304173	
59		OTHER ANCILLARY SERVICE C		22,326	22,326	2.894966	2.894966	
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	20,000	21,074	41,074	4.460437	4.460437	
61		EMERGENCY	110,648	3,333,476	3,444,124	.516227	.516227	
62		OBSERVATION BEDS (NON-DIS	849	9,679	10,528	.921638	.921638	
63		FAMILY PRACTICE						
63	50	RURAL HEALTH CLINIC	136,329	1,179,742	1,316,071	1.034035	1.034035	
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES		1,042,414	1,042,414	.756586	.756586	
101		SUBTOTAL	6,073,293	16,748,642	22,821,935			
102		LESS OBSERVATION BEDS						
103		TOTAL	6,073,293	16,748,642	22,821,935			

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	738,912	71,058	667,854			738,912
40		ANESTHESIOLOGY	50,226	5,017	45,209			50,226
41		RADIOLOGY-DIAGNOSTIC	1,467,897	158,236	1,309,661			1,467,897
44		LABORATORY	1,259,321	18,724	1,240,597			1,259,321
46		WHOLE BLOOD & PACKED RED	85,871	948	84,923			85,871
49		RESPIRATORY THERAPY	317,255	8,290	308,965			317,255
50		PHYSICAL THERAPY	239,340	8,688	230,652			239,340
50	01	CARDIAC REHAB	52,050	15,101	36,949			52,050
53		ELECTROCARDIOLOGY						
55		MEDICAL SUPPLIES CHARGED	75,982	936	75,046			75,982
56		DRUGS CHARGED TO PATIENTS	491,812	5,319	486,493			491,812
59		OTHER ANCILLARY SERVICE C	64,633	219	64,414			64,633
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	183,208	32,438	150,770			183,208
61		EMERGENCY	1,777,950	35,263	1,742,687			1,777,950
62		OBSERVATION BEDS (NON-DIS	9,703		9,703			9,703
63		FAMILY PRACTICE						
63	50	RURAL HEALTH CLINIC	1,360,864	100,830	1,260,034			1,360,864
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	788,676	12,907	775,769			788,676
101		SUBTOTAL	8,963,700	473,974	8,489,726			8,963,700
102		LESS OBSERVATION BEDS	9,703		9,703			9,703
103		TOTAL	8,953,997	473,974	8,480,023			8,953,997

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	1,500,204	.492541	.492541
40		ANESTHESIOLOGY	269,475	.186385	.186385
41		RADIOLOGY-DIAGNOSTIC	5,071,845	.289421	.289421
44		LABORATORY	4,816,505	.261460	.261460
46		WHOLE BLOOD & PACKED RED	310,609	.276460	.276460
49		RESPIRATORY THERAPY	627,807	.505338	.505338
50		PHYSICAL THERAPY	336,275	.711739	.711739
50	01	CARDIAC REHAB	43,350	1.200692	1.200692
53		ELECTROCARDIOLOGY			
55		MEDICAL SUPPLIES CHARGED	806,421	.094221	.094221
56		DRUGS CHARGED TO PATIENTS	1,616,880	.304173	.304173
59		OTHER ANCILLARY SERVICE C	22,326	2.894966	2.894966
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	41,074	4.460437	4.460437
61		EMERGENCY	3,444,124	.516227	.516227
62		OBSERVATION BEDS (NON-DIS	10,528	.921638	.921638
63		FAMILY PRACTICE			
63	50	RURAL HEALTH CLINIC	1,316,071	1.034035	1.034035
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES	1,042,414	.756586	.756586
101		SUBTOTAL	21,275,908		
102		LESS OBSERVATION BEDS	10,528		
103		TOTAL	21,265,380		

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	738,912	71,058	667,854			738,912
40		ANESTHESIOLOGY	50,226	5,017	45,209			50,226
41		RADIOLOGY-DIAGNOSTIC	1,467,897	158,236	1,309,661			1,467,897
44		LABORATORY	1,259,321	18,724	1,240,597			1,259,321
46		WHOLE BLOOD & PACKED RED	85,871	948	84,923			85,871
49		RESPIRATORY THERAPY	317,255	8,290	308,965			317,255
50		PHYSICAL THERAPY	239,340	8,688	230,652			239,340
50	01	CARDIAC REHAB	52,050	15,101	36,949			52,050
53		ELECTROCARDIOLOGY						
55		MEDICAL SUPPLIES CHARGED	75,982	936	75,046			75,982
56		DRUGS CHARGED TO PATIENTS	491,812	5,319	486,493			491,812
59		OTHER ANCILLARY SERVICE C	64,633	219	64,414			64,633
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	183,208	32,438	150,770			183,208
61		EMERGENCY	1,777,950	35,263	1,742,687			1,777,950
62		OBSERVATION BEDS (NON-DIS	9,703		9,703			9,703
63		FAMILY PRACTICE						
63	50	RURAL HEALTH CLINIC	1,360,864	100,830	1,260,034			1,360,864
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	788,676	12,907	775,769			788,676
101		SUBTOTAL	8,963,700	473,974	8,489,726			8,963,700
102		LESS OBSERVATION BEDS	9,703		9,703			9,703
103		TOTAL	8,953,997	473,974	8,480,023			8,953,997

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	1,500,204	.492541	.492541
40		ANESTHESIOLOGY	269,475	.186385	.186385
41		RADIOLOGY-DIAGNOSTIC	5,071,845	.289421	.289421
44		LABORATORY	4,816,505	.261460	.261460
46		WHOLE BLOOD & PACKED RED	310,609	.276460	.276460
49		RESPIRATORY THERAPY	627,807	.505338	.505338
50		PHYSICAL THERAPY	336,275	.711739	.711739
50	01	CARDIAC REHAB	43,350	1.200692	1.200692
53		ELECTROCARDIOLOGY			
55		MEDICAL SUPPLIES CHARGED	806,421	.094221	.094221
56		DRUGS CHARGED TO PATIENTS	1,616,880	.304173	.304173
59		OTHER ANCILLARY SERVICE C	22,326	2.894966	2.894966
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	41,074	4.460437	4.460437
61		EMERGENCY	3,444,124	.516227	.516227
62		OBSERVATION BEDS (NON-DIS	10,528	.921638	.921638
63		FAMILY PRACTICE			
63	50	RURAL HEALTH CLINIC	1,316,071	1.034035	1.034035
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES	1,042,414	.756586	.756586
101		SUBTOTAL	21,275,908		
102		LESS OBSERVATION BEDS	10,528		
103		TOTAL	21,265,380		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET D PART V

COMPONENT NO: 14-1344

TITLE XVIII, PART B HOSPITAL

		Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9) 1	Cost/Charge Ratio (C, Pt I, col. 9) 1.01	Cost/Charge Ratio (C, Pt II, col. 9) 1.02	Outpatient Ambulatory Surgical Ctr 2	Outpatient Radialogy 3
(A)		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	.492541		.492541		
40		ANESTHESIOLOGY	.186385		.186385		
41		RADIOLOGY-DIAGNOSTIC	.289421		.289421		
44		LABORATORY	.261460		.261460		
46		WHOLE BLOOD & PACKED RED BLOOD CELLS	.276460		.276460		
49		RESPIRATORY THERAPY	.505338		.505338		
50		PHYSICAL THERAPY	.711739		.711739		
50	01	CARDIAC REHAB	1.200692		1.200692		
53		ELECTROCARDIOLOGY					
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.094221		.094221		
56		DRUGS CHARGED TO PATIENTS	.304173		.304173		
59		OTHER ANCILLARY SERVICE COST CENTERS	2.894966		2.894966		
		OUTPAT SERVICE COST CNTRS					
60		CLINIC	4.460437		4.460437		
61		EMERGENCY	.516227		.516227		
62		OBSERVATION BEDS (NON-DISTINCT PART)	.921638		.921638		
63		FAMILY PRACTICE					
63	50	RURAL HEALTH CLINIC					
		OTHER REIMBURS COST CNTRS					
65		AMBULANCE SERVICES	.756586		.756586		
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: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET D | PART V | COMPONENT NO: 14-1344

TITLE XVIII, PART B HOSPITAL

		Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
			4	5	6	7	8
(A)		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM		439,670			
40		ANESTHESIOLOGY		21,039			
41		RADIOLOGY-DIAGNOSTIC		1,408,103			
44		LABORATORY		1,571,178			
46		WHOLE BLOOD & PACKED RED BLOOD CELLS		42,185			
49		RESPIRATORY THERAPY		149,584			
50		PHYSICAL THERAPY		129,747			
50	01	CARDIAC REHAB		17,309			
53		ELECTROCARDIOLOGY					
55		MEDICAL SUPPLIES CHARGED TO PATIENTS		33,201			
56		DRUGS CHARGED TO PATIENTS		272,889			
59		OTHER ANCILLARY SERVICE COST CENTERS					
		OUTPAT SERVICE COST CNTRS					
60		CLINIC		24,867			
61		EMERGENCY		1,108,304			
62		OBSERVATION BEDS (NON-DISTINCT PART)		1,896			
63		FAMILY PRACTICE					
63	50	RURAL HEALTH CLINIC					
		OTHER REIMBURS COST CNTRS					
65		AMBULANCE SERVICES					
101		SUBTOTAL		5,219,972			
102		CRNA CHARGES					
103		LESS PBP CLINIC LAB SVCS-					
		PROGRAM ONLY CHARGES					
104		NET CHARGES		5,219,972			

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1344 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/23/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1344 I I

TITLE XVIII, PART B HOSPITAL

		Cost Center Description	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
			9	10	11
(A)		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	216,556		
40		ANESTHESIOLOGY	3,921		
41		RADIOLOGY-DIAGNOSTIC	407,535		
44		LABORATORY	410,800		
46		WHOLE BLOOD & PACKED RED BLOOD CELLS	11,662		
49		RESPIRATORY THERAPY	75,590		
50		PHYSICAL THERAPY	92,346		
50	01	CARDIAC REHAB	20,783		
53		ELECTROCARDIOLOGY			
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	3,128		
56		DRUGS CHARGED TO PATIENTS	83,005		
59		OTHER ANCILLARY SERVICE COST CENTERS			
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	110,918		
61		EMERGENCY	572,136		
62		OBSERVATION BEDS (NON-DISTINCT PART)	1,747		
63		FAMILY PRACTICE			
63	50	RURAL HEALTH CLINIC			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		SUBTOTAL	2,010,127		
102		CRNA CHARGES			
103		LESS PBP CLINIC LAB SVCS-			
		PROGRAM ONLY CHARGES			
104		NET CHARGES	2,010,127		

(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: 14-1344	PERIOD: FROM 7/ 1/2009	PREPARED 11/23/2010
COMPONENT NO: 14-1344	TO 6/30/2010	WORKSHEET D PART VI

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.304173
2	PROGRAM VACCINE CHARGES	
3	PROGRAM COSTS	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET D | PART V | COMPONENT NO: 14-1344

TITLE XIX - O/P HOSPITAL

		Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All Other (1)
			1	2	3	4	5
(A)		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	.492541				462,714
40		ANESTHESIOLOGY	.186385				130,686
41		RADIOLOGY-DIAGNOSTIC	.289421				1,250,487
44		LABORATORY	.261460				849,930
46		WHOLE BLOOD & PACKED RED BLOOD CELLS	.276460				11,876
49		RESPIRATORY THERAPY	.505338				28,476
50		PHYSICAL THERAPY	.711739				34,341
50	01	CARDIAC REHAB	1.200692				
53		ELECTROCARDIOLOGY					
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.094221				55,637
56		DRUGS CHARGED TO PATIENTS	.304173				122,079
59		OTHER ANCILLARY SERVICE COST CENTERS	2.894966				
		OUTPAT SERVICE COST CNTRS					
60		CLINIC	4.460437				
61		EMERGENCY	.516227				1,470,117
62		OBSERVATION BEDS (NON-DISTINCT PART)	.921638				
63		FAMILY PRACTICE					
63	50	RURAL HEALTH CLINIC	1.034035				667,232
		OTHER REIMBURS COST CNTRS					
65		AMBULANCE SERVICES	.756586				146,925
101		SUBTOTAL					5,230,500
102		CRNA CHARGES					
103		LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104		NET CHARGES					5,230,500

(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: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET D | PART V | COMPONENT NO: 14-1344

TITLE XIX - O/P HOSPITAL

(A)		Cost Center Description	PPS Services FYB to 12/31 5.01	Non-PPS Services 5.02	PPS Services 1/1 to FYE 5.03	Outpatient Ambulatory Surgical Ctr 6	Outpatient Radialogy 7
(A)		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM					
40		ANESTHESIOLOGY					
41		RADIOLOGY-DIAGNOSTIC					
44		LABORATORY					
46		WHOLE BLOOD & PACKED RED BLOOD CELLS					
49		RESPIRATORY THERAPY					
50		PHYSICAL THERAPY					
50	01	CARDIAC REHAB					
53		ELECTROCARDIOLOGY					
55		MEDICAL SUPPLIES CHARGED TO PATIENTS					
56		DRUGS CHARGED TO PATIENTS					
59		OTHER ANCILLARY SERVICE COST CENTERS					
		OUTPAT SERVICE COST CNTRS					
60		CLINIC					
61		EMERGENCY					
62		OBSERVATION BEDS (NON-DISTINCT PART)					
63		FAMILY PRACTICE					
63	50	RURAL HEALTH CLINIC					
		OTHER REIMBURS COST CNTRS					
65		AMBULANCE SERVICES					
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: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET D | PART V | COMPONENT NO: 14-1344

TITLE XIX - O/P HOSPITAL

(A)		Cost Center Description	Other Outpatient Diagnostic 8	All Other 9	PPS Services FYB to 12/31 9.01	Non-PPS Services 9.02	PPS Services 1/1 to FYE 9.03
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM		227,906			
40		ANESTHESIOLOGY		24,358			
41		RADIOLOGY-DIAGNOSTIC		361,917			
44		LABORATORY		222,223			
46		WHOLE BLOOD & PACKED RED BLOOD CELLS		3,283			
49		RESPIRATORY THERAPY		14,390			
50		PHYSICAL THERAPY		24,442			
50	01	CARDIAC REHAB					
53		ELECTROCARDIOLOGY					
55		MEDICAL SUPPLIES CHARGED TO PATIENTS		5,242			
56		DRUGS CHARGED TO PATIENTS		37,133			
59		OTHER ANCILLARY SERVICE COST CENTERS					
		OUTPAT SERVICE COST CNTRS					
60		CLINIC					
61		EMERGENCY		758,914			
62		OBSERVATION BEDS (NON-DISTINCT PART)					
63		FAMILY PRACTICE					
63	50	RURAL HEALTH CLINIC		689,941			
		OTHER REIMBURS COST CNTRS					
65		AMBULANCE SERVICES		111,161			
101		SUBTOTAL		2,480,910			
102		CRNA CHARGES					
103		LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104		NET CHARGES		2,480,910			

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

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
14-1344	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART I
14-1344		

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)	2,957
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,358
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,358
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
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)	561
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	38
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,793
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
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)	561
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	168.58
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	168.58
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,185,037
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	6,406
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	425,114
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,759,923
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,485,212
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,485,212
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.184964
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	629.86
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	1,759,923

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	746.36
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,338,223
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,338,223

		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	742,918
49	TOTAL PROGRAM INPATIENT COSTS	2,081,141
	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)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	418,708
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	418,708
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 11/23/2010
14-1344	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART III
14-1344		

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	13
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	746.36
85	OBSERVATION BED COST	9,703

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					

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
14-1344	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART I
14-1344		

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	2,957
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,358
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,358
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
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)	561
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	38
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	307
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	168.58
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	168.58
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	6,406
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	5,177
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	-5,177
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,485,212
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,485,212
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	- .003486
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	629.86
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	-5,177

TITLE XIX - I/P 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	- 2.19
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	-672
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	-672

		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					263,864
49	TOTAL PROGRAM INPATIENT COSTS					263,192

	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	263,192
	TARGET AMOUNT AND LIMIT COMPUTATION	
54	PROGRAM DISCHARGES	118
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)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	
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 11/23/2010
14-1344	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART III
14-1344		

TITLE XIX - I/P 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		13
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	-	2.20
85	OBSERVATION BED COST		-29

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 11/23/2010
14-1344	FROM 7/ 1/2009	WORKSHEET D-4
COMPONENT NO:	TO 6/30/2010	
14-1344		

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		1,046,476	
31		SUBPROVIDER			
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.492541	90,807	44,726
40		ANESTHESIOLOGY	.186385	5,815	1,084
41		RADIOLOGY-DIAGNOSTIC	.289421	328,032	94,939
44		LABORATORY	.261460	613,706	160,460
46		WHOLE BLOOD & PACKED RED BLOOD CELLS	.276460	90,451	25,006
49		RESPIRATORY THERAPY	.505338	273,642	138,282
50		PHYSICAL THERAPY	.711739	34,882	24,827
50	01	CARDIAC REHAB	1.200692		
53		ELECTROCARDIOLOGY			
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.094221	465,789	43,887
56		DRUGS CHARGED TO PATIENTS	.304173	685,999	208,662
59		OTHER ANCILLARY SERVICE COST CENTERS	2.894966		
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	4.460437		
61		EMERGENCY	.516227	2,024	1,045
62		OBSERVATION BEDS (NON-DISTINCT PART)	.921638		
63		FAMILY PRACTICE			
63	50	RURAL HEALTH CLINIC			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		TOTAL		2,591,147	742,918
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		2,591,147	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET D-4 | COMPONENT NO: 14-Z344

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			
31		SUBPROVIDER			
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.492541	3,387	1,668
40		ANESTHESIOLOGY	.186385		
41		RADIOLOGY-DIAGNOSTIC	.289421	15,843	4,585
44		LABORATORY	.261460	59,549	15,570
46		WHOLE BLOOD & PACKED RED BLOOD CELLS	.276460	3,583	991
49		RESPIRATORY THERAPY	.505338	89,415	45,185
50		PHYSICAL THERAPY	.711739	38,476	27,385
50	01	CARDIAC REHAB	1.200692		
53		ELECTROCARDIOLOGY			
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.094221	163,922	15,445
56		DRUGS CHARGED TO PATIENTS	.304173	218,290	66,398
59		OTHER ANCILLARY SERVICE COST CENTERS	2.894966		
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	4.460437		
61		EMERGENCY	.516227		
62		OBSERVATION BEDS (NON-DISTINCT PART)	.921638		
63		FAMILY PRACTICE			
63	50	RURAL HEALTH CLINIC			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		TOTAL		592,465	177,227
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		592,465	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
14-1344	FROM 7/ 1/2009	WORKSHEET D-4
COMPONENT NO:	TO 6/30/2010	
14-1344		

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.		COST CENTER DESCRIPTION	RATIO COST TO CHARGES	INPATIENT CHARGES	INPATIENT COST
			1	2	3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS		181,713	
31		SUBPROVIDER			
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.492541	57,712	28,426
40		ANESTHESIOLOGY	.186385	18,550	3,457
41		RADIOLOGY-DIAGNOSTIC	.289421	78,086	22,600
44		LABORATORY	.261460	95,726	25,029
46		WHOLE BLOOD & PACKED RED BLOOD CELLS	.276460	13,577	3,753
49		RESPIRATORY THERAPY	.505338	44,397	22,435
50		PHYSICAL THERAPY	.711739	4,357	3,101
50	01	CARDIAC REHAB	1.200692		
53		ELECTROCARDIOLOGY			
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.094221	53,902	5,079
56		DRUGS CHARGED TO PATIENTS	.304173	139,038	42,292
59		OTHER ANCILLARY SERVICE COST CENTERS	2.894966		
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	4.460437	19,087	85,136
61		EMERGENCY	.516227	9,322	4,812
62		OBSERVATION BEDS (NON-DISTINCT PART)	.921638		
63		FAMILY PRACTICE			
63	50	RURAL HEALTH CLINIC	1.034035	17,160	17,744
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		TOTAL		550,914	263,864
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		550,914	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
14-1344	FROM 7/ 1/2009	WORKSHEET E
COMPONENT NO:	TO 6/30/2010	PART B
14-1344		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,010,127
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)	2,010,127
	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)	2,030,228
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	33,037
18.01	CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	724,178
19	SUBTOTAL (SEE INSTRUCTIONS)	1,273,013
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	1,273,013
24	PRIMARY PAYER PAYMENTS	589
25	SUBTOTAL	1,272,424
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	271,562
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	271,562
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	244,993
28	SUBTOTAL	1,543,986
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	1,543,986
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	1,737,002
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-193,016
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

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/23/2010
I	14-1344	I	FROM 7/ 1/2009	I	WORKSHEET E-1
I	COMPONENT NO:	I	TO 6/30/2010	I	
I	14-1344	I		I	

TITLE XVIII HOSPITAL

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	P A R T B MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,648,828		1,688,002
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	1/29/2010	10,200	1/29/2010	49,000
	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		10,200		49,000
4	TOTAL INTERIM PAYMENTS			1,659,028		1,737,002
	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		108,399		
		SETTLEMENT TO PROGRAM .02				193,016
7	TOTAL MEDICARE PROGRAM LIABILITY			1,767,427		1,543,986

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

I PROVIDER NO:	I PERIOD:	I PREPARED 11/23/2010
I 14-1344	I FROM 7/ 1/2009	I WORKSHEET E-1
I COMPONENT NO:	I TO 6/30/2010	I
I 14-Z344	I	I

TITLE XVIII SWING BED SNF

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	P A R T B MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			541,638		
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				
	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		NONE
4	TOTAL INTERIM PAYMENTS			541,638		
	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		50,087		
7	TOTAL MEDICARE PROGRAM LIABILITY			591,725		

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: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010
COMPONENT NO: 14-Z344 | WORKSHEET E-2

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)	422,895	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	178,999	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	561	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	601,894	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	601,894	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	601,894	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	10,169	
14	80% OF PART B COSTS		
15	SUBTOTAL	591,725	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	591,725	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	541,638	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	50,087	
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 11/23/2010
14-1344	FROM 7/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2010	PART II
14-1344		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT
HOSPITAL

1	INPATIENT SERVICES	2,081,141
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,081,141
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,101,952
	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	2,101,952
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	396,139
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,705,813
23	COINSURANCE	
24	SUBTOTAL	1,705,813
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	61,614
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	61,614
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	55,378
26	SUBTOTAL	1,767,427
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	1,767,427
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	1,659,028
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	108,399
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET E-3 | PART III | COMPONENT NO: -

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

		TITLE XIX HOSPITAL	TITLE XVIII SNF PPS
		TITLE V OR TITLE XIX	
		1	2
	COMPUTATION OF NET COST OF COVERED SERVICE		
1	INPATIENT HOSPITAL/SNF/NF SERVICES	263,192	
2	MEDICAL AND OTHER SERVICES	2,480,910	
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)		
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		
6	SUBTOTAL	2,744,102	
7	INPATIENT PRIMARY PAYER PAYMENTS		
8	OUTPATIENT PRIMARY PAYER PAYMENTS		
9	SUBTOTAL	2,744,102	
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
10	ROUTINE SERVICE CHARGES	181,713	
11	ANCILLARY SERVICE CHARGES	5,781,414	
12	INTERNS AND RESIDENTS SERVICE CHARGES		
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE		
14	TEACHING PHYSICIANS		
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION		
16	TOTAL REASONABLE CHARGES	5,963,127	
	CUSTOMARY CHARGES		
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
18	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)		
19	RATIO OF LINE 17 TO LINE 18		
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	5,963,127	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	3,219,025	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
23	COST OF COVERED SERVICES	2,744,102	
	PROSPECTIVE PAYMENT AMOUNT		
24	OTHER THAN OUTLIER PAYMENTS		
25	OUTLIER PAYMENTS		
26	PROGRAM CAPITAL PAYMENTS		
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS		
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		
30	SUBTOTAL	2,744,102	
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30	2,744,102	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
34	EXCESS OF REASONABLE COST		
35	SUBTOTAL	2,744,102	
36	COINSURANCE		
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19		
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)		
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)		
39	UTILIZATION REVIEW		
40	SUBTOTAL (SEE INSTRUCTIONS)	2,744,102	
41	INPATIENT ROUTINE SERVICE COST		
42	MEDICARE INPATIENT ROUTINE CHARGES		
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES		
45	RATIO OF LINE 43 TO 44		
46	TOTAL CUSTOMARY CHARGES		
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
50	OTHER ADJUSTMENTS (SPECIFY)		
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
52	SUBTOTAL	2,744,102	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/23/2010
14-1344	FROM 7/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2010	PART III
-		

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	TITLE XIX HOSPITAL	TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	2,744,102	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
57	INTERIM PAYMENTS	2,744,102	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
58	BALANCE DUE PROVIDER/PROGRAM		
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

BALANCE SHEET | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | 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	803,878			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	3,737,386			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,146,953			
7	INVENTORY	245,357			
8	PREPAID EXPENSES	109,290			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	2,748,958			
	FIXED ASSETS				
12	LAND	20,150			
12.01					
13	LAND IMPROVEMENTS	349,421			
13.01	LESS ACCUMULATED DEPRECIATION	-155,411			
14	BUILDINGS	5,333,809			
14.01	LESS ACCUMULATED DEPRECIATION	-2,777,158			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	499,757			
16.01	LESS ACCUMULATED DEPRECIATION	-336,444			
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	4,490,132			
18.01	LESS ACCUMULATED DEPRECIATION	-3,727,354			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	3,696,902			
	OTHER ASSETS				
22	INVESTMENTS	1,222			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS	1,222			
27	TOTAL ASSETS	6,447,082			

BALANCE SHEET | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET G

	LIABILITIES AND FUND BALANCE	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	857,898			
29	SALARIES, WAGES & FEES PAYABLE	545,183			
30	PAYROLL TAXES PAYABLE	16,457			
31	NOTES AND LOANS PAYABLE (SHORT TERM)				
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES	605,719			
36	TOTAL CURRENT LIABILITIES	2,025,257			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE	212,624			
38	NOTES PAYABLE				
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES	212,624			
43	TOTAL LIABILITIES	2,237,881			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	4,209,201			
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	4,209,201			
52	TOTAL LIABILITIES AND FUND BALANCES	6,447,082			

STATEMENT OF CHANGES IN FUND BALANCES | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET G-1

		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD	4,398,223			
2	NET INCOME (LOSS)	-189,022			
3	TOTAL	4,209,201			
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL	4,209,201			
	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	4,209,201			

		ENDOWMENT FUND 5	6	PLANT FUND 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: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | 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	1,485,212		1,485,212
2	00	SUBPROVIDER			
4	00	SWING BED - SNF	171,913		171,913
5	00	SWING BED - NF			
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	1,657,125		1,657,125
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	1,657,125		1,657,125
17	00	ANCILLARY SERVICES	4,308,772	16,255,065	20,563,837
18	00	OUTPATIENT SERVICES			
18	50	RURAL HEALTH CLINIC		1,319,458	1,319,458
20	00	AMBULANCE SERVICES		1,045,097	1,045,097
24	00	NRCC	209,296		209,296
25	00	TOTAL PATIENT REVENUES	6,175,193	18,619,620	24,794,813

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		12,382,369
		ADD (SPECIFY)		
27	00	EXPESNES NOT ON WKST A - BAD DEBT	1,333,360	
28	00			
29	00			
30	00			
31	00			
32	00			
33	00	TOTAL ADDITIONS		1,333,360
		DEDUCT (SPECIFY)		
34	00	DEDUCT (SPECIFY)		
35	00			
36	00			
37	00			
38	00			
39	00	TOTAL DEDUCTIONS		
40	00	TOTAL OPERATING EXPENSES		13,715,729

STATEMENT OF REVENUES AND EXPENSES | PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	24,794,813
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	12,006,484
3	NET PATIENT REVENUES	12,788,329
4	LESS: TOTAL OPERATING EXPENSES	13,715,729
5	NET INCOME FROM SERVICE TO PATIENTS	-927,400
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	94,017
7	INCOME FROM INVESTMENTS	3,703
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	1
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	74,129
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	5,229
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	
23	GOVERNMENTAL APPROPRIATIONS	274,327
24	OTHER INCOME	286,972
25	TOTAL OTHER INCOME	738,378
26	TOTAL	-189,022
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	-189,022

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

PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET M-1

COMPONENT NO: 14-3499

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN				
2	PHYSICIAN ASSISTANT	65,443		65,443	
3	NURSE PRACTITIONER	77,978		77,978	
4	VISITING NURSE				
5	OTHER NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS	209,646		209,646	
10	SUBTOTAL (SUM OF LINES 1-9)	353,067		353,067	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT		381,158	381,158	
12	PHYSICIAN SUPERVISION UNDER AGREEMENT				
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)		381,158	381,158	
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		6,234	6,234	
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE		23,624	23,624	
19	OTHER HEALTH CARE COSTS		19,821	19,821	
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		49,679	49,679	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	353,067	430,837	783,904	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY		3,547	3,547	
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS		190	190	
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		3,737	3,737	
	FACILITY OVERHEAD				
29	FACILITY COSTS		4,026	4,026	11,969
30	ADMINISTRATIVE COSTS		68,303	68,303	
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		72,329	72,329	11,969
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	353,067	506,903	859,970	11,969

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

PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET M-1

COMPONENT NO: 14-3499

RHC 1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN			
2	PHYSICIAN ASSISTANT	65,443		65,443
3	NURSE PRACTITIONER	77,978		77,978
4	VISITING NURSE			
5	OTHER NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS	209,646		209,646
10	SUBTOTAL (SUM OF LINES 1-9)	353,067		353,067
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT	381,158	-56,200	324,958
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)	381,158	-56,200	324,958
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	6,234		6,234
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE	23,624		23,624
19	OTHER HEALTH CARE COSTS	19,821		19,821
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	49,679		49,679
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	783,904	-56,200	727,704
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY	3,547		3,547
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS	190	-190	
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	3,737	-190	3,547
	FACILITY OVERHEAD			
29	FACILITY COSTS	15,995		15,995
30	ADMINISTRATIVE COSTS	68,303		68,303
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	84,298		84,298
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	871,939	-56,390	815,549

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET M-2

COMPONENT NO: 14-3499

RHC 1

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	1.40	4,865	4,200	5,880
2	PHYSICIAN ASSISTANTS	.85	2,057	2,100	1,785
3	NURSE PRACTITIONERS	.74	1,798	2,100	1,554
4	SUBTOTAL (SUM OF LINES 1-3)	2.99	8,720		9,219
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.99	8,720		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	727,704			
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	3,547			
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	731,251			
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	.995149			
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	84,298			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	545,315			
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	629,613			
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	629,613			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	626,559			
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,354,263			

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET M-2

COMPONENT NO: 14-3499

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)	9,219
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	9,219
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

I PROVIDER NO: 14-1344 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I COMPONENT NO: 14-3499 I PREPARED 11/23/2010 I WORKSHEET M-3

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)	1,354,263		
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)			
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,354,263		
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	9,219		
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)			
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	9,219		
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	146.90		
		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)	146.90	146.90	
	CALCULATION OF SETTLEMENT			
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		2,810	
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		412,789	
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)*		412,789	
16.01	PRIMARY PAYER AMOUNT			
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		34,682	
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		378,107	
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		302,486	
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)			
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		302,486	
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		738	
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)		303,224	
25	INTERIM PAYMENTS		264,954	
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		38,270	
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2			

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

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

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

[X] RHC [ ] FQHC

PROVIDER NO: 14-1344 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/23/2010 | WORKSHEET M-5

COMPONENT NO: 14-3499

RHC 1

	DESCRIPTION		PART B MM/DD/YYYY 1	PART B AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			237,454
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	2/16/2010	27,500
	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		27,500
4	TOTAL INTERIM PAYMENTS			264,954
	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		38,270
7	TOTAL MEDICARE PROGRAM LIABILITY			303,224

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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