

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	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	14-1323	I	FROM 4/ 1/2010	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 3/31/2011	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 8/18/2011 TIME 11:05

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:  
 MASSAC MEMORIAL HOSPITAL 14-1323

FOR THE COST REPORTING PERIOD BEGINNING 4/ 1/2010 AND ENDING 3/31/2011 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

\_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2	3	4		
1	HOSPITAL	0	309,417	75,973		0
3	SWING BED - SNF	0	65,739	0		0
9	RHC	0	0	-2,581		0
100	TOTAL	0	375,156	73,392		0

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 28 CHICK STREET P.O. BOX:  
 1.01 CITY: METROPOLIS STATE: IL ZIP CODE: 62960- COUNTY: MASSAC

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	14-1323		2/ 1/2003	N	0	0
04.00	SWING BED - SNF	14-2323		2/ 1/2003	N	0	N
14.00	HOSPITAL-BASED RHC	14-3478		2/ 7/2006	N	0	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 4/ 1/2010 TO: 3/31/2011

18 TYPE OF CONTROL 11 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1  
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. Y
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
- 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION (OR APPLICABLE EXTENSION) OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105, MIPPA §147, ACA §3121 OR MMEA §108? "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 IN COL 1 "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 §3121 or MMEA §108? 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. 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? N

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 OR "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 OR "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)

25.07 HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THE COST REPORTING  
 PERIOD? ENTER "Y" FOR YES OR "N" FOR NO IN COLUMN 1.

25.08 IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE UNWEIGHTED NUMBER OF NON-PRIMARY CARE FTE  
 RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. 0.00

IF LINE 25.07 IS YES, USE LINES 25.09 THROUGH 25.59 AS NECESSARY TO IDENTIFY THE PROGRAM  
 NAME IN COLUMN 1, THE PROGRAM CODE IN COLUMN 2, AND THE NUMBER OF UNWEIGHTED PRIMARY  
 CARE RESIDENTS FTES BY PROGRAM IN COLUMN 3 FOR EACH PRIMARY CARE SPECIALTY PROGRAM  
 IN WHICH RESIDENTS ARE TRAINED. (SEE INSTRUCTIONS)

25.09 0000 0.00

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 2/ 1/2003

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

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. 1 2 3 4  
 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)

28.03 STAFFING % Y/N 0.00%

28.04 RECRUITMENT 0.00%

28.05 RETENTION 0.00%

28.06 TRAINING 0.00%

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

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

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

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

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

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

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

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

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

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

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

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

MISCELLANEOUS COST REPORT INFORMATION

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

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

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

TITLE XIX INPATIENT SERVICES

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

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?  
 IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME  
 OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS). N

40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #  
 40.02 STREET: P.O. BOX:  
 40.03 CITY: STATE: ZIP CODE: -

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N  
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.  
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?  
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?  
 46 IF YOU ARE PARTICIPATING IN THE NHCMP 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: 295,674  
 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 N  
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH  
 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

		DATE	Y OR N	LIMIT	Y OR N	FEES
		0	1	2	3	4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		N			
58	ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		N			
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).				0	
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		N			
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)		N			
60.01	IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC).		N		0	

MULTICAMPUS

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

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).

MISCELLANEOUS DATA

64.00 DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO.

HOSPITAL AND HOSPITAL HEALTH CARE  
 COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 8/18/2011  
 I 14-1323 I FROM 4/ 1/2010 I WORKSHEET S-3  
 I TO 3/31/2011 I PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	25	9,125	88,914.00		2,774		342
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF					529		
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	9,125	88,914.00		3,303		342
6 INTENSIVE CARE UNIT							
12 TOTAL	25	9,125	88,914.00		3,303		342
13 RPCH VISITS							
24 RURAL HEALTH CLINIC					987		5,642
25 TOTAL	25						
26 OBSERVATION BED DAYS							30
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	DISCHARGES NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			3,706				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			541				
4 ADULTS & PED-SB NF			23				
5 TOTAL ADULTS AND PEDS			4,270				
6 INTENSIVE CARE UNIT							
12 TOTAL			4,270				
13 RPCH VISITS							
24 RURAL HEALTH CLINIC			8,516				
25 TOTAL							
26 OBSERVATION BED DAYS			286				
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

COMPONENT	I & R FTES NET 9	--- FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV --- NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					712	246	2,056
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
12 TOTAL		172.68			712	246	2,056
13 RPCH VISITS							
24 RURAL HEALTH CLINIC		6.86					
25 TOTAL		179.54					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							
29 LABOR & DELIVERY DAYS							

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 28 CHICK STREET  
 1.01 CITY: METROPOLIS STATE: IL ZIP CODE: 62960 COUNTY: MASSAC  
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

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

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

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12 CLINIC			800	1630	800	1630	800	1630	800	1630	800	1630		

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION).

LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

TITLE V TITLE XVIII TITLE XIX

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

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

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSESI PROVIDER NO:  
I 14-1323  
II PERIOD:  
I FROM 4/ 1/2010  
I TO 3/31/2011 II PREPARED 8/18/2011  
I WORKSHEET A  
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		832,115	832,115	457,546	1,289,661
3.01	0301 NEW CAP REL COSTS-BLDG AMBULANCE				24,000	24,000
3.02	0302 NEW CAP REL COSTS-BLDG EKG				14,400	14,400
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		665,399	665,399	242,122	907,521
5	0500 EMPLOYEE BENEFITS	102,203	2,386,324	2,488,527		2,488,527
6	0600 ADMINISTRATIVE & GENERAL	1,007,933	1,421,659	2,429,592	-179,145	2,250,447
8	0800 OPERATION OF PLANT	271,803	653,317	925,120	-16,746	908,374
9	0900 LAUNDRY & LINEN SERVICE	14,575	88,918	103,493		103,493
10	1000 HOUSEKEEPING	283,013	57,739	340,752		340,752
11	1100 DIETARY	270,758	168,701	439,459	-186,158	253,301
12	1200 CAFETERIA				185,506	185,506
14	1400 NURSING ADMINISTRATION	492,438	12,712	505,150		505,150
17	1700 MEDICAL RECORDS & LIBRARY	226,414	28,269	254,683		254,683
18	1800 SOCIAL SERVICE	144,155	7,075	151,230		151,230
20	2000 NONPHYSICIAN ANESTHETISTS					
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,468,595	278,440	1,747,035	-309	1,746,726
26	2600 INTENSIVE CARE UNIT					
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	281,741	227,096	508,837	-88,074	420,763
40	4000 ANESTHESIOLOGY		318,904	318,904		318,904
41	4100 RADIOLOGY-DIAGNOSTIC	533,795	646,719	1,180,514	-117,349	1,063,165
44	4400 LABORATORY	460,454	592,338	1,052,792	-40,833	1,011,959
49	4900 RESPIRATORY THERAPY	316,470	85,754	402,224	-22,078	380,146
50	5000 PHYSICAL THERAPY	388,087	17,831	405,918	-1,203	404,715
53	5300 ELECTROCARDIOLOGY	97,400	170,079	267,479	6,806	274,285
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	71,308	15,262	86,570	90,649	177,219
56	5600 DRUGS CHARGED TO PATIENTS	223,643	502,415	726,058	-9,536	716,522
59	3020 GERIATRIC PSYCH	83,756	73,343	157,099		157,099
	OUTPAT SERVICE COST CNTRS					
61	6100 EMERGENCY	623,296	534,834	1,158,130	116,056	1,274,186
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICES					
63.50	6310 RURAL HEALTH CLINIC	430,285	253,736	684,021		684,021
	OTHER REIMBURS COST CNTRS					
64	6400 HOME PROGRAM DIALYSIS					
65	6500 AMBULANCE SERVICES	433,613	88,525	522,138	-24,000	498,138
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		546,975	546,975	-546,975	
90	9000 OTHER CAPITAL RELATED COSTS		25,851	25,851	-25,851	
95	SUBTOTALS	8,225,735	10,700,330	18,926,065	-121,172	18,804,893
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES	18,632	6,006	24,638	84,318	108,956
98.01	9801 PROMOTION				36,854	36,854
99	9900 NONPAID WORKERS					
101	TOTAL	8,244,367	10,706,336	18,950,703	-0-	18,950,703



RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSESI PROVIDER NO:  
I 14-1323  
II PERIOD:  
I FROM 4/ 1/2010  
I TO 3/31/2011 II PREPARED 8/18/2011  
I WORKSHEET A  
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-126,960	1,162,701
3.01	0301 NEW CAP REL COSTS-BLDG AMBULANCE		24,000
3.02	0302 NEW CAP REL COSTS-BLDG EKG		14,400
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-14,455	893,066
5	0500 EMPLOYEE BENEFITS	-225	2,488,302
6	0600 ADMINISTRATIVE & GENERAL	-267,220	1,983,227
8	0800 OPERATION OF PLANT	-2,870	905,504
9	0900 LAUNDRY & LINEN SERVICE		103,493
10	1000 HOUSEKEEPING		340,752
11	1100 DIETARY	-1,084	252,217
12	1200 CAFETERIA	-68,030	117,476
14	1400 NURSING ADMINISTRATION		505,150
17	1700 MEDICAL RECORDS & LIBRARY	-1,396	253,287
18	1800 SOCIAL SERVICE		151,230
20	2000 NONPHYSICIAN ANESTHETISTS		
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-144,873	1,601,853
26	2600 INTENSIVE CARE UNIT		
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		420,763
40	4000 ANESTHESIOLOGY	-318,904	
41	4100 RADIOLOGY-DIAGNOSTIC		1,063,165
44	4400 LABORATORY		1,011,959
49	4900 RESPIRATORY THERAPY		380,146
50	5000 PHYSICAL THERAPY		404,715
53	5300 ELECTROCARDIOLOGY	-90,540	183,745
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-13,141	164,078
56	5600 DRUGS CHARGED TO PATIENTS	-4,119	712,403
59	3020 GERIATRIC PSYCH		157,099
	OUTPAT SERVICE COST CNTRS		
61	6100 EMERGENCY	-77,166	1,197,020
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICES		
63.50	6310 RURAL HEALTH CLINIC		684,021
	OTHER REIMBURS COST CNTRS		
64	6400 HOME PROGRAM DIALYSIS		
65	6500 AMBULANCE SERVICES	-40	498,098
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-1,131,023	17,673,870
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		108,956
98.01	9801 PROMOTION		36,854
99	9900 NONPAID WORKERS		
101	TOTAL	-1,131,023	17,819,680

COST CENTERS USED IN COST REPORT

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
3.01	NEW CAP REL COSTS-BLDG AMBULANCE	0301	NEW CAP REL COSTS-BLDG & FIXT
3.02	NEW CAP REL COSTS-BLDG EKG	0302	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	GERIATRIC PSYCH	3020	ACUPUNCTURE
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICES	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
64	HOME PROGRAM DIALYSIS	6400	
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	PROMOTION	9801	PHYSICIANS' PRIVATE OFFICES
99	NONPAID WORKERS	9900	
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141323	FROM 4/ 1/2010	8/18/2011
	TO 3/31/2011	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 TO RECLASS INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		507,266
2		NEW CAP REL COSTS-MVBLE EQUIP	4		39,709
3 TO RECLASS CAFETERIA EXPENSE	B	CAFETERIA	12	114,293	71,213
4 TO RECLASS RENTAL EXPENSE	C	NEW CAP REL COSTS-MVBLE EQUIP	4		195,794
5					
6					
7					
8					
9					
10					
11					
12 TO RECLASS MEDICAL SUPPLY EXPENSE	D	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		101,876
13					
14					
15					
16					
17					
18					
19					
20					
21 TO RECLASS DRUG COSTS	E	DRUGS CHARGED TO PATIENTS	56		652
22 TO RECLASS PROF BUILD COSTS	F	PHYSICIANS' PRIVATE OFFICES	98		68,952
23					
24 TO RECLASS EKG SALARIES	G	ELECTROCARDIOLOGY	53	21,206	
25 TO RECLASS PROFESSIONAL BUILDING CST	J	PHYSICIANS' PRIVATE OFFICES	98	2,431	12,935
26 TO RECLASS ER PHY MALPRACTICE	N	EMERGENCY	61		135,047
27 TO RECLASS AMBULANCE RENTAL EXPENSE	O	NEW CAP REL COSTS-BLDG AMBULANCE	3.01		24,000
28 TO RECLASS SLEEP LAB RENTAL EXPENSE	P	NEW CAP REL COSTS-BLDG EKG	3.02		14,400
29 TO RECLASS MARKETING EXPENSES	U	PROMOTION	98.01		36,854
30 A-8 SALARY FOR B-1 PURPOSES	V	ADMINISTRATIVE & GENERAL	6		789
36 TOTAL RECLASSIFICATIONS				137,930	1,209,487

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141323	FROM 4/ 1/2010	8/18/2011
	TO 3/31/2011	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE			A-7 REF
			LINE NO	SALARY	OTHER	
	1	6	7	8	9	10
1 TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	88		546,975	11
2						11
3 TO RECLASS CAFETERIA EXPENSE	B	DIETARY	11	114,293	71,213	
4 TO RECLASS RENTAL EXPENSE	C	OPERATION OF PLANT	8		1,380	10
5		RADIOLOGY-DIAGNOSTIC	41		114,218	
6		LABORATORY	44		40,648	
7		PHYSICAL THERAPY	50		1,045	
8		MEDICAL SUPPLIES CHARGED TO PATIENTS	55		3,429	
9		OPERATING ROOM	37		27,574	
10		ADMINISTRATIVE & GENERAL	6		7,244	
11		RESPIRATORY THERAPY	49		256	
12 TO RECLASS MEDICAL SUPPLY EXPENSE	D	RADIOLOGY-DIAGNOSTIC	41		3,131	
13		ADULTS & PEDIATRICS	25		309	
14		MEDICAL SUPPLIES CHARGED TO PATIENTS	55		7,798	
15		LABORATORY	44		185	
16		OPERATING ROOM	37		60,500	
17		RESPIRATORY THERAPY	49		616	
18		EMERGENCY	61		18,991	
19		DRUGS CHARGED TO PATIENTS	56		10,188	
20		PHYSICAL THERAPY	50		158	
21 TO RECLASS DRUG COSTS	E	DIETARY	11		652	
22 TO RECLASS PROF BUILD COSTS	F	NEW CAP REL COSTS-BLDG & FIXT	3		68,715	9
23		NEW CAP REL COSTS-MVBLE EQUIP	4		237	9
24 TO RECLASS EKG SALARIES	G	RESPIRATORY THERAPY	49	21,206		
25 TO RECLASS PROFESSIONAL BUILDING CST	J	OPERATION OF PLANT	8	2,431	12,935	
26 TO RECLASS ER PHY MALPRACTICE	N	ADMINISTRATIVE & GENERAL	6		135,047	
27 TO RECLASS AMBULANCE RENTAL EXPENSE	O	AMBULANCE SERVICES	65		24,000	10
28 TO RECLASS SLEEP LAB RENTAL EXPENSE	P	ELECTROCARDIOLOGY	53		14,400	10
29 TO RECLASS MARKETING EXPENSES	U	ADMINISTRATIVE & GENERAL	6		36,854	
30 A-8 SALARY FOR B-1 PURPOSES	V	ADMINISTRATIVE & GENERAL	6	789		
36 TOTAL RECLASSIFICATIONS				138,719	1,208,698	

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141323	FROM 4/ 1/2010	8/18/2011
	TO 3/31/2011	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A  
EXPLANATION : TO RECLASS INTEREST EXPENSE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	507,266	INTEREST EXPENSE	88	546,975	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	39,709			0	
TOTAL RECLASSIFICATIONS FOR CODE A			546,975				546,975

RECLASS CODE: B  
EXPLANATION : TO RECLASS CAFETERIA EXPENSE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	CAFETERIA	12	185,506	DIETARY	11	185,506	
TOTAL RECLASSIFICATIONS FOR CODE B			185,506				185,506

RECLASS CODE: C  
EXPLANATION : TO RECLASS RENTAL EXPENSE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	195,794	OPERATION OF PLANT	8	1,380	
2.00			0	RADIOLOGY-DIAGNOSTIC	41	114,218	
3.00			0	LABORATORY	44	40,648	
4.00			0	PHYSICAL THERAPY	50	1,045	
5.00			0	MEDICAL SUPPLIES CHARGED TO PA	55	3,429	
6.00			0	OPERATING ROOM	37	27,574	
7.00			0	ADMINISTRATIVE & GENERAL	6	7,244	
8.00			0	RESPIRATORY THERAPY	49	256	
TOTAL RECLASSIFICATIONS FOR CODE C			195,794				195,794

RECLASS CODE: D  
EXPLANATION : TO RECLASS MEDICAL SUPPLY EXPENSE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	101,876	RADIOLOGY-DIAGNOSTIC	41	3,131	
2.00			0	ADULTS & PEDIATRICS	25	309	
3.00			0	MEDICAL SUPPLIES CHARGED TO PA	55	7,798	
4.00			0	LABORATORY	44	185	
5.00			0	OPERATING ROOM	37	60,500	
6.00			0	RESPIRATORY THERAPY	49	616	
7.00			0	EMERGENCY	61	18,991	
9.00			0	DRUGS CHARGED TO PATIENTS	56	10,188	
10.00			0	PHYSICAL THERAPY	50	158	
TOTAL RECLASSIFICATIONS FOR CODE D			101,876				101,876

RECLASS CODE: E  
EXPLANATION : TO RECLASS DRUG COSTS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	DRUGS CHARGED TO PATIENTS	56	652	DIETARY	11	652	
TOTAL RECLASSIFICATIONS FOR CODE E			652				652

RECLASS CODE: F  
EXPLANATION : TO RECLASS PROF BUILD COSTS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	PHYSICIANS' PRIVATE OFFICES	98	68,952	NEW CAP REL COSTS-BLDG & FIXT	3	68,715	
2.00			0	NEW CAP REL COSTS-MVBLE EQUIP	4	237	
TOTAL RECLASSIFICATIONS FOR CODE F			68,952				68,952

RECLASS CODE: G  
EXPLANATION : TO RECLASS EKG SALARIES

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ELECTROCARDIOLOGY	53	21,206	RESPIRATORY THERAPY	49	21,206	
TOTAL RECLASSIFICATIONS FOR CODE G			21,206				21,206

RECLASS CODE: J  
EXPLANATION : TO RECLASS PROFESSIONAL BUILDING CST

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	PHYSICIANS' PRIVATE OFFICES	98	15,366	OPERATION OF PLANT	8	15,366	
TOTAL RECLASSIFICATIONS FOR CODE J			15,366				15,366

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141323	FROM 4/ 1/2010	8/18/2011
	TO 3/31/2011	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: N  
 EXPLANATION : TO RECLASS ER PHY MALPRACTICE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	EMERGENCY	61	135,047	ADMINISTRATIVE & GENERAL	6	135,047	
TOTAL RECLASSIFICATIONS FOR CODE N			135,047				

RECLASS CODE: O  
 EXPLANATION : TO RECLASS AMBULANCE RENTAL EXPENSE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG AMBULAN	3.01	24,000	AMBULANCE SERVICES	65	24,000	
TOTAL RECLASSIFICATIONS FOR CODE O			24,000				

RECLASS CODE: P  
 EXPLANATION : TO RECLASS SLEEP LAB RENTAL EXPENSE

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG EKG	3.02	14,400	ELECTROCARDIOLOGY	53	14,400	
TOTAL RECLASSIFICATIONS FOR CODE P			14,400				

RECLASS CODE: U  
 EXPLANATION : TO RECLASS MARKETING EXPENSES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	PROMOTION	98.01	36,854	ADMINISTRATIVE & GENERAL	6	36,854	
TOTAL RECLASSIFICATIONS FOR CODE U			36,854				

RECLASS CODE: V  
 EXPLANATION : A-8 SALARY FOR B-1 PURPOSES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	789	ADMINISTRATIVE & GENERAL	6	789	
TOTAL RECLASSIFICATIONS FOR CODE V			789				

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	ACQUISITIONS		TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES	PURCHASES	DONATION		AND		BALANCE
		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	ACQUISITIONS		TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES	PURCHASES	DONATION		AND		BALANCE
		1	2	3	4	5	6	7
1	LAND	13,981					13,981	
2	LAND IMPROVEMENTS	1,089,309				33,373	1,055,936	
3	BUILDINGS & FIXTURE	17,821,687	309,559		309,559	68,096	18,063,150	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	7,678,523	876,234		876,234	1,648,593	6,906,164	
7	SUBTOTAL	26,603,500	1,185,793		1,185,793	1,750,062	26,039,231	
8	RECONCILING ITEMS							
9	TOTAL	26,603,500	1,185,793		1,185,793	1,750,062	26,039,231	

PART III - RECONCILIATION OF CAPITAL COST CENTERS  
 DESCRIPTION

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	19,133,067		19,133,067	.734778	18,995			18,995
3 01	NEW CAP REL COSTS-BL								
3 02	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV	6,906,164		6,906,164	.265222	6,856			6,856
5	TOTAL	26,039,231		26,039,231	1.000000	25,851			25,851

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	763,400		380,306	18,995			1,162,701
3 01	NEW CAP REL COSTS-BL		24,000					24,000
3 02	NEW CAP REL COSTS-BL		14,400					14,400
4	NEW CAP REL COSTS-MV	660,645	195,794	29,771	6,856			893,066
5	TOTAL	1,424,045	234,194	410,077	25,851			2,094,167

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	832,115						832,115
3 01	NEW CAP REL COSTS-BL							
3 02	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV	665,399						665,399
5	TOTAL	1,497,514						1,497,514

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



ADJUSTMENTS TO EXPENSES

DESCRIPTION (1)	(2)		EXPENSE CLASSIFICATION ON			WKST. A-7 REF. 5
	BASIS/CODE 1	AMOUNT 2	WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4		
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	B	-126,960	NEW CAP REL COSTS-BLDG &	3	11	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-9,938	NEW CAP REL COSTS-MVBLE E	4	11	
5 INVESTMENT INCOME-OTHER						
6 TRADE, QUANTITY AND TIME DISCOUNTS						
7 REFUNDS AND REBATES OF EXPENSES						
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS						
9 TELEPHONE SERVICES	A	-7,658	ADMINISTRATIVE & GENERAL	6		
10 TELEVISION AND RADIO SERVICE						
11 PARKING LOT						
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-312,579				
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1					
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS						
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS						
18 SALE OF MED AND SURG SUPPLIES						
19 SALE OF DRUGS TO OTHER THAN PATIENTS						
20 SALE OF MEDICAL RECORDS & ABSTRACTS	A	-1,396	MEDICAL RECORDS & LIBRARY	17		
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)						
22 VENDING MACHINES						
23 INCOME FROM IMPOSITION OF INTEREST						
24 INTRST EXP ON MEDICARE OVERPAYMENTS						
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		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 TELEVISION	A	-2,870	OPERATION OF PLANT	8		
38 OTHER OPERATING REVENUE	B	-24,420	ADMINISTRATIVE & GENERAL	6		
39 OTHER NON OPERATING REVENUE	B	-25,095	ADMINISTRATIVE & GENERAL	6		
40 ACCOUNTS PAYABLE DISCOUNT	B	-3,088	ADMINISTRATIVE & GENERAL	6		
41 PHARMACY REBATES	B	-4,119	DRUGS CHARGED TO PATIENTS	56		
42 PURCHASING REBATES	B	-13,141	MEDICAL SUPPLIES CHARGED	55		
43 DIETARY REVENUE	B	-68,030	CAFETERIA	12		
44 AMBULANCE SERVICE	B	-40	AMBULANCE SERVICES	65		
45 OTHER ADJUSTMENTS (SPECIFY)						
46 LOBBYING EXPENSE	A	-7,951	ADMINISTRATIVE & GENERAL	6		
47 CRNA EXPENSES	A	-318,904	ANESTHESIOLOGY	40		
48 DIETARY REBATES	B	-1,084	DIETARY	11		
49 COMMUNITY OUTREACH	A	-2,289	ADMINISTRATIVE & GENERAL	6		
49.01 PATIENT TV DEPRECIATION	A	-1,578	NEW CAP REL COSTS-MVBLE E	4	9	
49.02 PATIENT PHONE SALARY	A	-828	ADMINISTRATIVE & GENERAL	6		
49.03 PATIENT PHONE BENEFITS	A	-225	EMPLOYEE BENEFITS	5		
49.04 PATIENT PHONE DEPRECIATION	A	-2,939	NEW CAP REL COSTS-MVBLE E	4	9	
49.05 PHYSICIAN RECRUITMENT	A	-195,891	ADMINISTRATIVE & GENERAL	6		
49.06						
49.07						
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,131,023				

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 14-1323 I

I PERIOD: I FROM 4/ 1/2010 I TO 3/31/2011 I

I PREPARED 8/18/2011 I WORKSHEET A-8-2 I GROUP 1

LINE NO.	WKSHT A 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN- ERATION 3	PROFES- SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	44	LABORATORY	11,000		11,000				
3	53	EKG	90,540	90,540					
4	61	EMERGENCY	411,727		411,727				
5	25	HOSPITALIST	144,873	144,873					
6	53	CARDIAC REHAB	13,200		13,200				
7	53	SLEEP LAB	35,828		35,828				
8	61	ER MALPRACTICE	135,047	77,166	57,881				
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	842,215	312,579	529,636				



COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 8/18/2011  
 I 14-1323 I FROM 4/ 1/2010 I NOT A CMS WORKSHEET  
 I I TO 3/31/2011 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
3.01	NEW CAP REL COSTS-BLDG AMBULANCE	4	SQUARE	FEET	ENTERED
3.02	NEW CAP REL COSTS-BLDG EKG	5	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	6	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	-8	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	10	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	11	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	12	TIME	SPENT	ENTERED
11	DIETARY	13	MEALS	SERVED	ENTERED
12	CAFETERIA	14	FTE		ENTERED
14	NURSING ADMINISTRATION	16	NURSING	FTES	ENTERED
17	MEDICAL RECORDS & LIBRARY	19	TIME	SPENT	ENTERED
18	SOCIAL SERVICE	20	ASSIGNEDTI	IMES	ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED	TIME	NOT ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION		NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-BLDG AM 3.01	NEW CAP REL C OSTS-BLDG EK 3.02	NEW CAP REL C OSTS-MVBLE E 4	EMPLOYEE BENE FITS 5	SUBTOTAL 5a.00
003	GENERAL SERVICE COST CNTR							
	NEW CAP REL COSTS-BLDG &	1,162,701	1,162,701					
003 01	NEW CAP REL COSTS-BLDG AM	24,000		24,000				
003 02	NEW CAP REL COSTS-BLDG EK	14,400			14,400			
004	NEW CAP REL COSTS-MVBLE E	893,066				893,066		
005	EMPLOYEE BENEFITS	2,488,302	5,557			4,040	2,497,899	
006	ADMINISTRATIVE & GENERAL	1,983,227	290,699			211,353	309,007	2,794,286
008	OPERATION OF PLANT	905,504	106,759			77,619	82,647	1,172,529
009	LAUNDRY & LINEN SERVICE	103,493	22,228			16,161	4,472	146,354
010	HOUSEKEEPING	340,752	8,185			5,951	86,833	441,721
011	DIETARY	252,217	26,758			19,454	48,006	346,435
012	CAFETERIA	117,476	11,196			8,140	35,067	171,879
014	NURSING ADMINISTRATION	505,150	4,654			3,383	151,087	664,274
017	MEDICAL RECORDS & LIBRARY	253,287	25,992		1,684	20,808	69,467	371,238
018	SOCIAL SERVICE	151,230	2,477			1,801	44,229	199,737
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	1,601,853	201,364			146,401	450,591	2,400,209
026	INTENSIVE CARE UNIT							
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	420,763	123,580			89,849	86,442	720,634
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	1,063,165	67,025			48,731	163,776	1,342,697
044	LABORATORY	1,011,959	16,301			11,852	141,274	1,181,386
049	RESPIRATORY THERAPY	380,146	22,543			16,390	90,591	509,670
050	PHYSICAL THERAPY	404,715	25,157			18,290	119,071	567,233
053	ELECTROCARDIOLOGY	183,745	23,774		12,716	31,714	36,390	288,339
055	MEDICAL SUPPLIES CHARGED	164,078	18,916			13,752	21,878	218,624
056	DRUGS CHARGED TO PATIENTS	712,403	7,802			5,672	68,617	794,494
059	GERIATRIC PSYCH	157,099	7,966			5,792	25,698	196,555
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	1,197,020	80,288			58,373	191,237	1,526,918
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICES							
063 50	RURAL HEALTH CLINIC	684,021	61,167			44,472	132,018	921,678
	OTHER REIMBURS COST CNTRS							
064	HOME PROGRAM DIALYSIS							
065	AMBULANCE SERVICES	498,098		24,000		31,386	133,039	686,523
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	17,673,870	1,160,388	24,000	14,400	891,384	2,491,437	17,663,413
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		2,313			1,682		3,995
098	PHYSICIANS' PRIVATE OFFIC	108,956					6,462	115,418
098 01	PROMOTION	36,854						36,854
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	17,819,680	1,162,701	24,000	14,400	893,066	2,497,899	17,819,680

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
	6	8	9	10	11	12	14
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG &							
003 02 NEW CAP REL COSTS-BLDG AM							
004 NEW CAP REL COSTS-BLDG EK							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL	2,794,286						
009 OPERATION OF PLANT	218,056	1,390,585					
010 LAUNDRY & LINEN SERVICE	27,218	40,687	214,259				
011 HOUSEKEEPING	82,147	14,982		538,850			
012 DIETARY	64,427	48,980		10,011	469,853		
014 CAFETERIA	31,965	20,494		9,540		233,878	
017 NURSING ADMINISTRATION	123,536	8,518				11,774	808,102
018 MEDICAL RECORDS & LIBRARY	69,040	47,577		3,575		11,660	
020 SOCIAL SERVICE	37,145	4,535				4,020	25,269
025 NONPHYSICIAN ANESTHETISTS							
026 INPAT ROUTINE SRVC CNTRS							
037 ADULTS & PEDIATRICS	446,366	368,593	130,875	243,962	411,637	61,670	387,648
040 INTENSIVE CARE UNIT							
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM	134,017	226,211	10,897	16,812		9,888	62,152
049 ANESTHESIOLOGY							
050 RADIOLOGY-DIAGNOSTIC	249,703	122,688	20,846	31,096		19,071	
053 LABORATORY	219,704	29,839		23,213		20,919	
055 RESPIRATORY THERAPY	94,784	41,264	474	20,531		12,574	
056 PHYSICAL THERAPY	105,489	46,049	5,093	13,830		9,354	
059 ELECTROCARDIOLOGY	53,623	43,518		8,654		1,600	
061 MEDICAL SUPPLIES CHARGED	40,658	34,624				3,848	
062 DRUGS CHARGED TO PATIENTS	147,753	14,281		3,349		4,820	30,296
063 GERIATRIC PSYCH	36,554	14,581				2,972	18,683
064 OUTPAT SERVICE COST CNTRS							
065 EMERGENCY	283,962	146,965	45,126	77,086		24,329	152,923
066 OBSERVATION BEDS (NON-DIS							
063 50 OTHER OUTPATIENT SERVICES							
063 50 RURAL HEALTH CLINIC	171,405	111,965		27,120		13,317	
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
095 AMBULANCE SERVICES	127,673					20,862	131,131
096 SPEC PURPOSE COST CENTERS							
098 SUBTOTALS	2,765,225	1,386,351	213,311	488,779	432,605	232,678	808,102
099 NONREIMBURS COST CENTERS							
101 GIFT, FLOWER, COFFEE SHOP	743	4,234					
102 PHYSICIANS' PRIVATE OFFIC	21,464		948	50,071	37,248	1,200	
103 01 PROMOTION	6,854						
104 NONPAID WORKERS							
105 CROSS FOOT ADJUSTMENT							
106 NEGATIVE COST CENTER							
103 TOTAL	2,794,286	1,390,585	214,259	538,850	469,853	233,878	808,102

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	18	20	25	26	27
003 GENERAL SERVICE COST CNTR						
003 01 NEW CAP REL COSTS-BLDG &						
003 02 NEW CAP REL COSTS-BLDG AM						
004 NEW CAP REL COSTS-MVBLE E						
005 EMPLOYEE BENEFITS						
006 ADMINISTRATIVE & GENERAL						
008 OPERATION OF PLANT						
009 LAUNDRY & LINEN SERVICE						
010 HOUSEKEEPING						
011 DIETARY						
012 CAFETERIA						
014 NURSING ADMINISTRATION						
017 MEDICAL RECORDS & LIBRARY	503,090					
018 SOCIAL SERVICE		270,706				
020 NONPHYSICIAN ANESTHETISTS						
025 INPAT ROUTINE SRVC CNTRS						
026 ADULTS & PEDIATRICS	251,941	270,706		4,973,607	-143,879	4,829,728
037 INTENSIVE CARE UNIT						
040 ANCILLARY SRVC COST CNTRS						
041 OPERATING ROOM	32,036			1,212,647		1,212,647
044 ANESTHESIOLOGY				1,786,101		1,786,101
049 RADIOLOGY-DIAGNOSTIC	51,021			1,526,082	36,454	1,562,536
050 LABORATORY	50,625			729,922		729,922
053 RESPIRATORY THERAPY				747,048		747,048
055 PHYSICAL THERAPY				395,734		395,734
056 ELECTROCARDIOLOGY				297,754		297,754
059 MEDICAL SUPPLIES CHARGED				994,993		994,993
061 GERIATRIC PSYCH				290,313		290,313
062 OUTPAT SERVICE COST CNTRS						
063 EMERGENCY	117,467			2,374,776	-1,409	2,373,367
063 50 OBSERVATION BEDS (NON-DIS					108,834	108,834
063 50 OTHER OUTPATIENT SERVICES						
064 RURAL HEALTH CLINIC				1,245,485		1,245,485
065 OTHER REIMBURS COST CNTRS						
095 HOME PROGRAM DIALYSIS						
095 50 AMBULANCE SERVICES				966,189		966,189
095 50 SPEC PURPOSE COST CENTERS						
095 50 SUBTOTALS	503,090	270,706		17,540,651		17,540,651
096 NONREIMBURS COST CENTERS						
098 GIFT, FLOWER, COFFEE SHOP				8,972		8,972
098 01 PHYSICIANS' PRIVATE OFFIC				226,349		226,349
099 PROMOTION				43,708		43,708
101 NONPAID WORKERS						
102 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 TOTAL	503,090	270,706		17,819,680		17,819,680

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-BLDG AM	NEW CAP REL C OSTS-BLDG EK	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS
	0	3	3.01	3.02	4	4a	5
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG AM							
003 02 NEW CAP REL COSTS-BLDG EK							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS		5,557			4,040	9,597	9,597
006 ADMINISTRATIVE & GENERAL		290,699			211,353	502,052	1,187
008 OPERATION OF PLANT		106,759			77,619	184,378	318
009 LAUNDRY & LINEN SERVICE		22,228			16,161	38,389	17
010 HOUSEKEEPING		8,185			5,951	14,136	334
011 DIETARY		26,758			19,454	46,212	184
012 CAFETERIA		11,196			8,140	19,336	135
014 NURSING ADMINISTRATION		4,654			3,383	8,037	581
017 MEDICAL RECORDS & LIBRARY		25,992		1,684	20,808	48,484	267
018 SOCIAL SERVICE		2,477			1,801	4,278	170
020 NONPHYSICIAN ANESTHETISTS							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		201,364			146,401	347,765	1,729
037 INTENSIVE CARE UNIT							
040 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM		123,580			89,849	213,429	332
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		67,025			48,731	115,756	629
044 LABORATORY		16,301			11,852	28,153	543
049 RESPIRATORY THERAPY		22,543			16,390	38,933	348
050 PHYSICAL THERAPY		25,157			18,290	43,447	458
053 ELECTROCARDIOLOGY		23,774		12,716	31,714	68,204	140
055 MEDICAL SUPPLIES CHARGED		18,916			13,752	32,668	84
056 DRUGS CHARGED TO PATIENTS		7,802			5,672	13,474	264
059 GERIATRIC PSYCH		7,966			5,792	13,758	99
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY		80,288			58,373	138,661	735
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICES							
063 50 RURAL HEALTH CLINIC		61,167			44,472	105,639	507
064 OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES			24,000		31,386	55,386	511
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		1,160,388	24,000	14,400	891,384	2,090,172	9,572
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		2,313			1,682	3,995	
098 PHYSICIANS' PRIVATE OFFIC							25
098 01 PROMOTION							
099 NONPAID WORKERS							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		1,162,701	24,000	14,400	893,066	2,094,167	9,597



ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
		6	8	9	10	11	12	14
003	GENERAL SERVICE COST CNTR							
003	01 NEW CAP REL COSTS-BLDG &							
003	02 NEW CAP REL COSTS-BLDG AM							
004	02 NEW CAP REL COSTS-BLDG EK							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL	503,239						
008	OPERATION OF PLANT	39,272	223,968					
009	LAUNDRY & LINEN SERVICE	4,902	6,553	49,861				
010	HOUSEKEEPING	14,795	2,413		31,678			
011	DIETARY	11,603	7,889		589	66,477		
012	CAFETERIA	5,757	3,301		561		29,090	
014	NURSING ADMINISTRATION	22,249	1,372				1,464	33,703
017	MEDICAL RECORDS & LIBRARY	12,434	7,663		210		1,450	
018	SOCIAL SERVICE	6,690	730				500	1,054
020	NONPHYSICIAN ANESTHETISTS							
025	INPAT ROUTINE SRVC CNTRS							
026	ADULTS & PEDIATRICS	80,383	59,365	30,457	14,341	58,240	7,670	16,167
026	INTENSIVE CARE UNIT							
037	ANCILLARY SRVC COST CNTRS							
040	OPERATING ROOM	24,136	36,434	2,536	988		1,230	2,592
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	44,971	19,760	4,851	1,828		2,372	
044	LABORATORY	39,568	4,806		1,365		2,602	
049	RESPIRATORY THERAPY	17,070	6,646	110	1,207		1,564	
050	PHYSICAL THERAPY	18,998	7,417	1,185	813		1,164	
053	ELECTROCARDIOLOGY	9,657	7,009		509		199	
055	MEDICAL SUPPLIES CHARGED	7,322	5,577				479	
056	DRUGS CHARGED TO PATIENTS	26,610	2,300		197		600	1,264
059	GERIATRIC PSYCH	6,583	2,348			2,967	370	779
061	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	51,141	23,670	10,501	4,532		3,026	6,378
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICES							
063	50 RURAL HEALTH CLINIC	30,870	18,033		1,594		1,656	
064	OTHER REIMBURS COST CNTRS							
064	HOME PROGRAM DIALYSIS							
065	AMBULANCE SERVICES	22,994					2,595	5,469
065	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	498,005	223,286	49,640	28,734	61,207	28,941	33,703
095	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP	134	682					
098	PHYSICIANS' PRIVATE OFFIC	3,866		221	2,944	5,270	149	
098	01 PROMOTION	1,234						
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	503,239	223,968	49,861	31,678	66,477	29,090	33,703

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	18	20	25	26	27
003 GENERAL SERVICE COST CNTR						
003 01 NEW CAP REL COSTS-BLDG &						
003 02 NEW CAP REL COSTS-BLDG AM						
004 NEW CAP REL COSTS-MVBLE E						
005 EMPLOYEE BENEFITS						
006 ADMINISTRATIVE & GENERAL						
008 OPERATION OF PLANT						
009 LAUNDRY & LINEN SERVICE						
010 HOUSEKEEPING						
011 DIETARY						
012 CAFETERIA						
014 NURSING ADMINISTRATION						
017 MEDICAL RECORDS & LIBRARY	70,508					
018 SOCIAL SERVICE		13,422				
020 NONPHYSICIAN ANESTHETISTS						
025 INPAT ROUTINE SRVC CNTRS						
026 ADULTS & PEDIATRICS	35,309	13,422		664,848		664,848
037 INTENSIVE CARE UNIT						
040 ANCILLARY SRVC COST CNTRS						
041 OPERATING ROOM	4,490			286,167		286,167
044 ANESTHESIOLOGY						
049 RADIOLOGY-DIAGNOSTIC				190,167		190,167
050 LABORATORY	7,151			84,188		84,188
053 RESPIRATORY THERAPY	7,095			72,973		72,973
055 PHYSICAL THERAPY				73,482		73,482
056 ELECTROCARDIOLOGY				85,718		85,718
059 MEDICAL SUPPLIES CHARGED				46,130		46,130
061 DRUGS CHARGED TO PATIENTS				44,709		44,709
062 GERIATRIC PSYCH				26,904		26,904
063 OUTPAT SERVICE COST CNTRS						
063 50 EMERGENCY	16,463			255,107		255,107
064 OBSERVATION BEDS (NON-DIS						
065 OTHER OUTPATIENT SERVICES						
063 50 RURAL HEALTH CLINIC				158,299		158,299
064 OTHER REIMBURS COST CNTRS						
065 HOME PROGRAM DIALYSIS						
095 AMBULANCE SERVICES				86,955		86,955
095 SPEC PURPOSE COST CENTERS						
095 SUBTOTALS	70,508	13,422		2,075,647		2,075,647
096 NONREIMBURS COST CENTERS						
098 GIFT, FLOWER, COFFEE SHOP				4,811		4,811
098 01 PHYSICIANS' PRIVATE OFFIC				12,475		12,475
099 PROMOTION				1,234		1,234
101 NONPAID WORKERS						
102 CROSS FOOT ADJUSTMENTS						
103 NEGATIVE COST CENTER						
103 TOTAL	70,508	13,422		2,094,167		2,094,167

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 8/18/2011  
 I 14-1323 I FROM 4/ 1/2010 I WORKSHEET B-1  
 I I TO 3/31/2011 I

COST CENTER DESCRIPTION	NEW CAP REL C OSTS-BLDG & (SQUARE FEET	NEW CAP REL C OSTS-BLDG AM (SQUARE )FEET	NEW CAP REL C OSTS-BLDG EK (SQUARE )FEET	NEW CAP REL C OSTS-MVBLE E (SQUARE )FEET	EMPLOYEE BENE FITS ( GROSS SALARIES )	RECONCILIATION
	3	3.01	3.02	4	5	6a.00
003 GENERAL SERVICE COST						
003 01 NEW CAP REL COSTS-BLD	84,949					
003 02 NEW CAP REL COSTS-BLD		3,154				
004 NEW CAP REL COSTS-MVB			1,642			
005 EMPLOYEE BENEFITS	406			89,745		
006 ADMINISTRATIVE & GENE	21,239			406	8,141,375	
008 OPERATION OF PLANT	7,800			21,239	1,007,144	-2,794,286
009 LAUNDRY & LINEN SERVI	1,624			7,800	269,372	
010 HOUSEKEEPING	598			1,624	14,575	
011 DIETARY	1,955			598	283,013	
012 CAFETERIA	818			1,955	156,465	
014 NURSING ADMINISTRATIO	340			818	114,293	
017 MEDICAL RECORDS & LIB	1,899		192	340	492,438	
018 SOCIAL SERVICE	181			2,091	226,414	
020 NONPHYSICIAN ANESTHET				181	144,155	
025 INPAT ROUTINE SRVC CN	14,712					
026 ADULTS & PEDIATRICS				14,712	1,468,595	
037 INTENSIVE CARE UNIT						
040 ANCILLARY SRVC COST C	9,029					
041 OPERATING ROOM				9,029	281,741	
044 ANESTHESIOLOGY	4,897					
049 RADIOLOGY-DIAGNOSTIC	1,191			4,897	533,795	
050 LABORATORY	1,647			1,191	460,454	
053 RESPIRATORY THERAPY	1,838			1,647	295,264	
055 PHYSICAL THERAPY	1,737		1,450	1,838	388,087	
056 ELECTROCARDIOLOGY	1,382			3,187	118,606	
059 MEDICAL SUPPLIES CHAR	570			1,382	71,308	
061 DRUGS CHARGED TO PATI	582			570	223,643	
062 GERIATRIC PSYCH				582	83,756	
063 OUTPAT SERVICE COST C	5,866					
064 EMERGENCY				5,866	623,296	
065 OBSERVATION BEDS (NON						
066 OTHER OUTPATIENT SERV						
063 50 RURAL HEALTH CLINIC	4,469			4,469	430,285	
064 OTHER REIMBURS COST C						
065 HOME PROGRAM DIALYSIS		3,154		3,154	433,613	
095 AMBULANCE SERVICES						
096 SPEC PURPOSE COST CEN	84,780	3,154	1,642	89,576	8,120,312	-2,794,286
098 SUBTOTALS						
099 NONREIMBURS COST CENT						
101 GIFT, FLOWER, COFFEE	169			169		
102 PHYSICIANS' PRIVATE O					21,063	
103 PROMOTION						
104 NONPAID WORKERS						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	1,162,701	24,000	14,400	893,066	2,497,899	
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	13.687048	7.609385	8.769793	9.951150	.306815	
(WRKSHT B, PT I)						
105 COST TO BE ALLOCATED						
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED					9,597	
(WRKSHT B, PART III						
108 UNIT COST MULTIPLIER					.001179	
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	(TIME SPENT)	(MEALS SERVED)	(FTE)	(NURSING FTES)
		6	8	9	10	11	12	14
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
003 01	NEW CAP REL COSTS-BLD							
003 02	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE	15,025,394						
008	OPERATION OF PLANT	1,172,529	55,504					
009	LAUNDRY & LINEN SERVI	146,354	1,624	1,809				
010	HOUSEKEEPING	441,721	598		154,484			
011	DIETARY	346,435	1,955		2,870	28,369		
012	CAFETERIA	171,879	818		2,735		12,276	
014	NURSING ADMINISTRATIO	664,274	340				618	140,358
017	MEDICAL RECORDS & LIB	371,238	1,899		1,025		612	
018	SOCIAL SERVICE	199,737	181				211	4,389
020	NONPHYSICIAN ANESTHET							
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	2,400,209	14,712	1,105	69,942	24,854	3,237	67,330
026	INTENSIVE CARE UNIT							
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	720,634	9,029	92	4,820		519	10,795
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	1,342,697	4,897	176	8,915		1,001	
044	LABORATORY	1,181,386	1,191		6,655		1,098	
049	RESPIRATORY THERAPY	509,670	1,647	4	5,886		660	
050	PHYSICAL THERAPY	567,233	1,838	43	3,965		491	
053	ELECTROCARDIOLOGY	288,339	1,737		2,481		84	
055	MEDICAL SUPPLIES CHAR	218,624	1,382				202	
056	DRUGS CHARGED TO PATI	794,494	570		960		253	5,262
059	GERIATRIC PSYCH	196,555	582			1,266	156	3,245
	OUTPAT SERVICE COST C							
061	EMERGENCY	1,526,918	5,866	381	22,100		1,277	26,561
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063 50	RURAL HEALTH CLINIC	921,678	4,469		7,775		699	
	OTHER REIMBURS COST C							
064	HOME PROGRAM DIALYSIS							
065	AMBULANCE SERVICES	686,523					1,095	22,776
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	14,869,127	55,335	1,801	140,129	26,120	12,213	140,358
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE	3,995	169					
098	PHYSICIANS' PRIVATE O	115,418		8	14,355	2,249	63	
098 01	PROMOTION	36,854						
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	2,794,286	1,390,585	214,259	538,850	469,853	233,878	808,102
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER	.185971	25.053780	118.440575	3.488063	16.562198	19.051645	5.757435
	(WRKSHT B, PT I)							
105	COST TO BE ALLOCATED							
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	503,239	223,968	49,861	31,678	66,477	29,090	33,703
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER	.033493	4.035169	27.562742	.205057	2.343297	2.369664	.240122
	(WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 8/18/2011  
 I 14-1323 I FROM 4/ 1/2010 I WORKSHEET B-1  
 I I TO 3/31/2011 I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS
	(TIME SPENT	(ASSIGNEDTI )IMES	(ASSIGNED ) TIME )
	17	18	20
003 GENERAL SERVICE COST			
003 01 NEW CAP REL COSTS-BLD			
003 02 NEW CAP REL COSTS-BLD			
004 NEW CAP REL COSTS-MVB			
005 EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENE			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVI			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATIO			
017 MEDICAL RECORDS & LIB	1,272		
018 SOCIAL SERVICE		4,300	
020 NONPHYSICIAN ANESTHET			
025 INPAT ROUTINE SRVC CN	637	4,300	
026 ADULTS & PEDIATRICS			
037 INTENSIVE CARE UNIT			
040 ANCILLARY SRVC COST C	81		
041 OPERATING ROOM			
044 ANESTHESIOLOGY			
049 RADIOLOGY-DIAGNOSTIC	129		
050 LABORATORY	128		
053 RESPIRATORY THERAPY			
055 PHYSICAL THERAPY			
056 ELECTROCARDIOLOGY			
059 MEDICAL SUPPLIES CHAR			
061 DRUGS CHARGED TO PATI			
062 GERIATRIC PSYCH			
063 OUTPAT SERVICE COST C	297		
063 50 EMERGENCY			
064 OBSERVATION BEDS (NON			
065 OTHER OUTPATIENT SERV			
064 50 RURAL HEALTH CLINIC			
065 OTHER REIMBURS COST C			
095 HOME PROGRAM DIALYSIS	1,272	4,300	
096 AMBULANCE SERVICES			
098 SPEC PURPOSE COST CEN			
098 01 SUBTOTALS			
099 NONREIMBURS COST CENT			
101 GIFT, FLOWER, COFFEE			
102 PHYSICIANS' PRIVATE O			
103 PROMOTION			
103 01 NONPAID WORKERS			
104 CROSS FOOT ADJUSTMENT			
105 NEGATIVE COST CENTER			
106 COST TO BE ALLOCATED	503,090	270,706	
107 (PER WRKSHT B, PART			
108 UNIT COST MULTIPLIER		62.954884	
105 (WRKSHT B, PT I)	395.511006		
106 COST TO BE ALLOCATED			
107 (PER WRKSHT B, PART			
108 UNIT COST MULTIPLIER		13,422	
107 (WRKSHT B, PT II)	70,508		
108 COST TO BE ALLOCATED			
107 (PER WRKSHT B, PART			
108 UNIT COST MULTIPLIER		3.121395	
107 (WRKSHT B, PT III)	55.430818		

POST STEP DOWN ADJUSTMENTS

I PROVIDER NO:  
I 14-1323  
I

I PERIOD: I PREPARED 8/18/2011  
I FROM 4/ 1/2010 I  
I TO 3/31/2011 I WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT
		PART	LINE NO.	
	1	2	3	4
1	ADJ FOR EPO COSTS IN RENAL DIA	1	57	
2	ADJ FOR EPO COSTS IN HOME PROG	1	64	
3	ADJ FOR ARANESP IN RENAL DIALY	1	57	
4	ADJ FOR ARANESP IN HOME PROGRA	1	64	
5	BLOOD ADMINISTRATION	1	44	36,454
6	BLOOD ADMINISTRATION	1	25	-143,879
7	BLOOD ADMINISTRATION	1	61	-1,409
8	OTHER OUTPATIENT SERVICES	1	63	108,834

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,829,728		4,829,728		
26	INTENSIVE CARE UNIT					
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	1,212,647		1,212,647		
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	1,786,101		1,786,101		
44	LABORATORY	1,562,536		1,562,536		
49	RESPIRATORY THERAPY	729,922		729,922		
50	PHYSICAL THERAPY	747,048		747,048		
53	ELECTROCARDIOLOGY	395,734		395,734		
55	MEDICAL SUPPLIES CHARGED	297,754		297,754		
56	DRUGS CHARGED TO PATIENTS	994,993		994,993		
59	GERIATRIC PSYCH	290,313		290,313		
61	OUTPAT SERVICE COST CNTRS EMERGENCY	2,373,367		2,373,367		
62	OBSERVATION BEDS (NON-DIS)	304,544		304,544		
63	OTHER OUTPATIENT SERVICES	108,834		108,834		
63	50 RURAL HEALTH CLINIC	1,245,485		1,245,485		
64	OTHER REIMBURS COST CNTRS HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES	966,189		966,189		
101	SUBTOTAL	17,845,195		17,845,195		
102	LESS OBSERVATION BEDS	304,544		304,544		
103	TOTAL	17,540,651		17,540,651		

I PROVIDER NO: I PERIOD: I PREPARED 8/18/2011  
 I 14-1323 I FROM 4/ 1/2010 I WORKSHEET C  
 I I TO 3/31/2011 I PART I

## COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,747,391		2,747,391			
26	INTENSIVE CARE UNIT						
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	41,875	3,141,202	3,183,077	.380967	.380967	
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	1,543,116	12,907,971	14,451,087	.123596	.123596	
44	LABORATORY	1,195,808	3,759,415	4,955,223	.315331	.315331	
49	RESPIRATORY THERAPY	492,155	319,591	811,746	.899200	.899200	
50	PHYSICAL THERAPY	146,037	816,429	962,466	.776181	.776181	
53	ELECTROCARDIOLOGY	462,310	1,357,560	1,819,870	.217452	.217452	
55	MEDICAL SUPPLIES CHARGED	19,629	116,147	135,776	2.192980	2.192980	
56	DRUGS CHARGED TO PATIENTS	1,489,837	1,389,498	2,879,335	.345563	.345563	
59	GERIATRIC PSYCH		223,429	223,429	1.299352	1.299352	
61	OUTPAT SERVICE COST CNTRS EMERGENCY	59,185	4,102,491	4,161,676	.570291	.570291	
62	OBSERVATION BEDS (NON-DIS	720	99,259	99,979	3.046080	3.046080	
63	OTHER OUTPATIENT SERVICES	1,000	366,050	367,050	.296510	.296510	
63	50 RURAL HEALTH CLINIC		739,437	739,437	1.684369	1.684369	
64	OTHER REIMBURS COST CNTRS HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES	34,322	1,650,072	1,684,394	.573612	.573612	
101	SUBTOTAL	8,233,385	30,988,551	39,221,936			
102	LESS OBSERVATION BEDS						
103	TOTAL	8,233,385	30,988,551	39,221,936			



WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	4,829,728		4,829,728		
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,212,647		1,212,647		
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	1,786,101		1,786,101		
44	LABORATORY	1,562,536		1,562,536		
49	RESPIRATORY THERAPY	729,922		729,922		
50	PHYSICAL THERAPY	747,048		747,048		
53	ELECTROCARDIOLOGY	395,734		395,734		
55	MEDICAL SUPPLIES CHARGED	297,754		297,754		
56	DRUGS CHARGED TO PATIENTS	994,993		994,993		
59	GERIATRIC PSYCH	290,313		290,313		
61	OUTPAT SERVICE COST CNTRS EMERGENCY	2,373,367		2,373,367		
62	OBSERVATION BEDS (NON-DIS)	304,544		304,544		
63	OTHER OUTPATIENT SERVICES	108,834		108,834		
63	50 RURAL HEALTH CLINIC	1,245,485		1,245,485		
64	OTHER REIMBURS COST CNTRS HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES	966,189		966,189		
101	SUBTOTAL	17,845,195		17,845,195		
102	LESS OBSERVATION BEDS	304,544		304,544		
103	TOTAL	17,540,651		17,540,651		

COMPUTATION OF RATIO OF COSTS TO CHARGES  
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,747,391		2,747,391			
26	INTENSIVE CARE UNIT						
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	41,875	3,141,202	3,183,077	.380967	.380967	
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	1,543,116	12,907,971	14,451,087	.123596	.123596	
44	LABORATORY	1,195,808	3,759,415	4,955,223	.315331	.315331	
49	RESPIRATORY THERAPY	492,155	319,591	811,746	.899200	.899200	
50	PHYSICAL THERAPY	146,037	816,429	962,466	.776181	.776181	
53	ELECTROCARDIOLOGY	462,310	1,357,560	1,819,870	.217452	.217452	
55	MEDICAL SUPPLIES CHARGED	19,629	116,147	135,776	2.192980	2.192980	
56	DRUGS CHARGED TO PATIENTS	1,489,837	1,389,498	2,879,335	.345563	.345563	
59	GERIATRIC PSYCH		223,429	223,429	1.299352	1.299352	
61	OUTPAT SERVICE COST CNTRS EMERGENCY	59,185	4,102,491	4,161,676	.570291	.570291	
62	OBSERVATION BEDS (NON-DIS	720	99,259	99,979	3.046080	3.046080	
63	OTHER OUTPATIENT SERVICES	1,000	366,050	367,050	.296510	.296510	
63	50 RURAL HEALTH CLINIC		739,437	739,437	1.684369	1.684369	
64	OTHER REIMBURS COST CNTRS HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES	34,322	1,650,072	1,684,394	.573612	.573612	
101	SUBTOTAL	8,233,385	30,988,551	39,221,936			
102	LESS OBSERVATION BEDS						
103	TOTAL	8,233,385	30,988,551	39,221,936			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,212,647	286,167	926,480			1,212,647
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	1,786,101	190,167	1,595,934			1,786,101
44	LABORATORY	1,562,536	84,188	1,478,348			1,562,536
49	RESPIRATORY THERAPY	729,922	72,973	656,949			729,922
50	PHYSICAL THERAPY	747,048	73,482	673,566			747,048
53	ELECTROCARDIOLOGY	395,734	85,718	310,016			395,734
55	MEDICAL SUPPLIES CHARGED	297,754	46,130	251,624			297,754
56	DRUGS CHARGED TO PATIENTS	994,993	44,709	950,284			994,993
59	GERIATRIC PSYCH	290,313	26,904	263,409			290,313
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,373,367	255,107	2,118,260			2,373,367
62	OBSERVATION BEDS (NON-DIS	304,544		304,544			304,544
63	OTHER OUTPATIENT SERVICES	108,834		108,834			108,834
63	50 RURAL HEALTH CLINIC	1,245,485	158,299	1,087,186			1,245,485
	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES	966,189	86,955	879,234			966,189
101	SUBTOTAL	13,015,467	1,410,799	11,604,668			13,015,467
102	LESS OBSERVATION BEDS	304,544		304,544			304,544
103	TOTAL	12,710,923	1,410,799	11,300,124			12,710,923

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	3,183,077	.380967	.380967
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	14,451,087	.123596	.123596
44	LABORATORY	4,955,223	.315331	.315331
49	RESPIRATORY THERAPY	811,746	.899200	.899200
50	PHYSICAL THERAPY	962,466	.776181	.776181
53	ELECTROCARDIOLOGY	1,819,870	.217452	.217452
55	MEDICAL SUPPLIES CHARGED	135,776	2.192980	2.192980
56	DRUGS CHARGED TO PATIENTS	2,879,335	.345563	.345563
59	GERIATRIC PSYCH	223,429	1.299352	1.299352
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	4,161,676	.570291	.570291
62	OBSERVATION BEDS (NON-DIS	99,979	3.046080	3.046080
63	OTHER OUTPATIENT SERVICES	367,050	.296510	.296510
63	50 RURAL HEALTH CLINIC	739,437	1.684369	1.684369
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES	1,684,394	.573612	.573612
101	SUBTOTAL	36,474,545		
102	LESS OBSERVATION BEDS	99,979		
103	TOTAL	36,374,566		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,212,647	286,167	926,480			1,212,647
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	1,786,101	190,167	1,595,934			1,786,101
44	LABORATORY	1,562,536	84,188	1,478,348			1,562,536
49	RESPIRATORY THERAPY	729,922	72,973	656,949			729,922
50	PHYSICAL THERAPY	747,048	73,482	673,566			747,048
53	ELECTROCARDIOLOGY	395,734	85,718	310,016			395,734
55	MEDICAL SUPPLIES CHARGED	297,754	46,130	251,624			297,754
56	DRUGS CHARGED TO PATIENTS	994,993	44,709	950,284			994,993
59	GERIATRIC PSYCH	290,313	26,904	263,409			290,313
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,373,367	255,107	2,118,260			2,373,367
62	OBSERVATION BEDS (NON-DIS	304,544		304,544			304,544
63	OTHER OUTPATIENT SERVICES	108,834		108,834			108,834
63	50 RURAL HEALTH CLINIC	1,245,485	158,299	1,087,186			1,245,485
	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES	966,189	86,955	879,234			966,189
101	SUBTOTAL	13,015,467	1,410,799	11,604,668			13,015,467
102	LESS OBSERVATION BEDS	304,544		304,544			304,544
103	TOTAL	12,710,923	1,410,799	11,300,124			12,710,923

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	3,183,077	.380967	.380967
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	14,451,087	.123596	.123596
44	LABORATORY	4,955,223	.315331	.315331
49	RESPIRATORY THERAPY	811,746	.899200	.899200
50	PHYSICAL THERAPY	962,466	.776181	.776181
53	ELECTROCARDIOLOGY	1,819,870	.217452	.217452
55	MEDICAL SUPPLIES CHARGED	135,776	2.192980	2.192980
56	DRUGS CHARGED TO PATIENTS	2,879,335	.345563	.345563
59	GERIATRIC PSYCH	223,429	1.299352	1.299352
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	4,161,676	.570291	.570291
62	OBSERVATION BEDS (NON-DIS	99,979	3.046080	3.046080
63	OTHER OUTPATIENT SERVICES	367,050	.296510	.296510
63	50 RURAL HEALTH CLINIC	739,437	1.684369	1.684369
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES	1,684,394	.573612	.573612
101	SUBTOTAL	36,474,545		
102	LESS OBSERVATION BEDS	99,979		
103	TOTAL	36,374,566		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
37	ANCILLARY SRVC COST CNTRS					
	OPERATING ROOM	1,212,647	3,183,077			
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	1,786,101	14,451,087			
44	LABORATORY	1,562,536	4,955,223			
49	RESPIRATORY THERAPY	729,922	811,746			
50	PHYSICAL THERAPY	747,048	962,466			
53	ELECTROCARDIOLOGY	395,734	1,819,870			
55	MEDICAL SUPPLIES CHARGED	297,754	135,776			
56	DRUGS CHARGED TO PATIENTS	994,993	2,879,335			
59	GERIATRIC PSYCH	290,313	223,429			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	2,373,367	4,161,676			
62	OBSERVATION BEDS (NON-DIS	304,544	99,979			
63	OTHER OUTPATIENT SERVICES	108,834	367,050			
63	50 RURAL HEALTH CLINIC	1,245,485	739,437			
	OTHER REIMBURS COST CNTRS					
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES	966,189	1,684,394			
101	TOTAL	13,015,467	36,474,545			

COMPUTATION OF OUTPATIENT COST PER VISIT -  
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 8/18/2011  
I 14-1323 I FROM 4/ 1/2010 I WORKSHEET C  
I TO 3/31/2011 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM	1,212,647		1,212,647	3,183,077			
40	ANESTHESIOLOGY							
41	RADIOLOGY-DIAGNOSTIC	1,786,101		1,786,101	14,451,087			
44	LABORATORY	1,562,536		1,562,536	4,955,223			
49	RESPIRATORY THERAPY	729,922		729,922	811,746			
50	PHYSICAL THERAPY	747,048		747,048	962,466			
53	ELECTROCARDIOLOGY	395,734	90,540	486,274	1,819,870			
55	MEDICAL SUPPLIES CHARGED	297,754		297,754	135,776			
56	DRUGS CHARGED TO PATIENTS	994,993		994,993	2,879,335			
59	GERIATRIC PSYCH	290,313		290,313	223,429			
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY	2,373,367	77,166	2,450,533	4,161,676			
62	OBSERVATION BEDS (NON-DIS	304,544		304,544	99,979			
63	OTHER OUTPATIENT SERVICES	108,834		108,834	367,050			
63	50 RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
64	HOME PROGRAM DIALYSIS							
65	AMBULANCE SERVICES	966,189		966,189	1,684,394			
101	TOTAL	11,769,982	167,706	11,937,688	35,735,108			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							



TITLE XVIII, PART B HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.380967		.380967		
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC	.123596		.123596		
44 LABORATORY	.315331		.315331		
49 RESPIRATORY THERAPY	.899200		.899200		
50 PHYSICAL THERAPY	.776181		.776181		
53 ELECTROCARDIOLOGY	.217452		.217452		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	2.192980		2.192980		
56 DRUGS CHARGED TO PATIENTS	.345563		.345563		
59 GERIATRIC PSYCH	1.299352		1.299352		
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY	.570291		.570291		
62 OBSERVATION BEDS (NON-DISTINCT PART)	3.046080		3.046080		
63 OTHER OUTPATIENT SERVICES	.296510		.296510		
63 50 RURAL HEALTH CLINIC					
OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES	.573612		.573612		
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)

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		1,316,227			
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		4,496,326			
44 LABORATORY		1,414,360			
49 RESPIRATORY THERAPY		179,451			
50 PHYSICAL THERAPY		201,316			
53 ELECTROCARDIOLOGY		578,073			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		52,142			
56 DRUGS CHARGED TO PATIENTS		949,647			
59 GERIATRIC PSYCH		209,693			
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY		1,252,541			
62 OBSERVATION BEDS (NON-DISTINCT PART)		47,360			
63 OTHER OUTPATIENT SERVICES		213,610			
63 50 RURAL HEALTH CLINIC					
OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		10,910,746			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES		10,910,746			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B		HOSPITAL		
		All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description		9	10	11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	501,439		
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	555,728		
44	LABORATORY	445,992		
49	RESPIRATORY THERAPY	161,362		
50	PHYSICAL THERAPY	156,258		
53	ELECTROCARDIOLOGY	125,703		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	114,346		
56	DRUGS CHARGED TO PATIENTS	328,163		
59	GERIATRIC PSYCH	272,465		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	714,313		
62	OBSERVATION BEDS (NON-DISTINCT PART)	144,262		
63	OTHER OUTPATIENT SERVICES	63,338		
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	3,583,369		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104	NET CHARGES	3,583,369		

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)	4,556
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,992
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,992
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	372
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)	169
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	19
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)	4
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,774
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	372
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)	157
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	121.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	125.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,829,728
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	2,299
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	500
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	578,877
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,250,851

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,659,849
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,659,849
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.598155
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	666.29
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	4,250,851

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,064.84
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2,953,866
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2,953,866

	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				
49	TOTAL PROGRAM INPATIENT COSTS				
					1,207,075
					4,160,941

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)	396,120
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	167,180
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	563,300
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A HOSPITAL OTHER

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	286
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,064.84
85	OBSERVATION BED COST	304,544

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				

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)	4,556
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,992
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,992
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	406
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)	135
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	17
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)	6
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	342
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	125.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	121.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,829,728
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	2,125
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	726
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	578,924
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,250,804

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,659,849
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,659,849
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.598137
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	666.29
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	4,250,804

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 1,064.83  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 364,172  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 364,172

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					
49 TOTAL PROGRAM INPATIENT COSTS					364,172

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)  
 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



TITLE XIX - I/P HOSPITAL OTHER

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	286
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,064.83
85	OBSERVATION BED COST	304,541

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

TITLE XVIII, PART A      HOSPITAL      OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,866,617	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.380967	29,770	11,341
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.123596	912,585	112,792
44	LABORATORY	.315331	789,061	248,815
49	RESPIRATORY THERAPY	.899200	402,774	362,174
50	PHYSICAL THERAPY	.776181	26,944	20,913
53	ELECTROCARDIOLOGY	.217452	311,283	67,689
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.192980	16,272	35,684
56	DRUGS CHARGED TO PATIENTS	.345563	1,005,764	347,555
59	GERIATRIC PSYCH OUTPAT SERVICE COST CNTRS	1.299352		
61	EMERGENCY	.570291		
62	OBSERVATION BEDS (NON-DISTINCT PART)	3.046080		
63	OTHER OUTPATIENT SERVICES	.296510	379	112
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
101	TOTAL		3,494,832	1,207,075
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,494,832	

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.380967	418	159
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.123596	14,615	1,806
44	LABORATORY	.315331	67,909	21,414
49	RESPIRATORY THERAPY	.899200	26,136	23,501
50	PHYSICAL THERAPY	.776181	115,107	89,344
53	ELECTROCARDIOLOGY	.217452	4,882	1,062
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.192980	1,085	2,379
56	DRUGS CHARGED TO PATIENTS	.345563	115,241	39,823
59	GERIATRIC PSYCH OUTPAT SERVICE COST CNTRS	1.299352		
61	EMERGENCY	.570291		
62	OBSERVATION BEDS (NON-DISTINCT PART)	3.046080		
63	OTHER OUTPATIENT SERVICES	.296510		
63	50 RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
101	TOTAL		345,393	179,488
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		345,393	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 3,583,369  
 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 OUTPATIENT ANCILLARY PASSTHRU COSTS FROM (W/S D,IV  
 (COLS 9, 9.01, 9.02) LINE 101  
 2 INTERNS AND RESIDENTS  
 3 ORGAN ACQUISITIONS  
 4 COST OF TEACHING PHYSICIANS  
 5 TOTAL COST (SEE INSTRUCTIONS) 3,583,369

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES  
 6 ANCILLARY SERVICE CHARGES  
 7 INTERNS AND RESIDENTS SERVICE CHARGES  
 8 ORGAN ACQUISITION CHARGES  
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.  
 10 TOTAL REASONABLE CHARGES  
 CUSTOMARY CHARGES  
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR  
 PAYMENT FOR SERVICES ON A CHARGE BASIS  
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE  
 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT  
 BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).  
 13 RATIO OF LINE 11 TO LINE 12  
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)  
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST  
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES  
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 3,619,203  
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 30,535  
 18.01 CAH ACTUAL BILLED COINSURANCE 1,889,468  
 LINE 17.01 (SEE INSTRUCTIONS)  
 19 SUBTOTAL (SEE INSTRUCTIONS) 1,699,200  
 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 1,699,200  
 24 PRIMARY PAYER PAYMENTS 622  
 25 SUBTOTAL 1,698,578

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD  
 27 BAD DEBTS (SEE INSTRUCTIONS)  
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)  
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES  
 28 SUBTOTAL 1,698,578  
 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 1,698,578  
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)  
 34 INTERIM PAYMENTS 1,622,605  
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)  
 35 BALANCE DUE PROVIDER/PROGRAM 75,973  
 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 ADJUSTMENT AMOUNT  
 (SEE INSTRUCTIONS)  
 52 THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY  
 53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)  
 54 TOTAL (SUM OF LINES 51 AND 53)

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,702,716		1,755,696
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	3/31/2011	481,371		
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROVIDER .49				
ADJUSTMENTS TO PROGRAM .50	10/26/2010	224,671	10/26/2010	133,091
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
ADJUSTMENTS TO PROGRAM .99		256,700		-133,091
4 TOTAL INTERIM PAYMENTS		3,959,416		1,622,605
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				
ADJUSTMENTS TO PROGRAM .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		309,417		75,973
7 TOTAL MEDICARE PROGRAM LIABILITY		4,268,833		1,698,578

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

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

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		689,276		
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 PROVIDER		.49		
ADJUSTMENTS TO PROGRAM	10/26/2010	10,857		
ADJUSTMENTS TO PROGRAM		.51		
ADJUSTMENTS TO PROGRAM		.52		
ADJUSTMENTS TO PROGRAM		.53		
ADJUSTMENTS TO PROGRAM		.54		
SUBTOTAL		.99		
4 TOTAL INTERIM PAYMENTS			-10,857	NONE
			678,419	
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)			65,739	
7 TOTAL MEDICARE PROGRAM LIABILITY			744,158	

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

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

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	568,933	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	181,283	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	529	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	750,216	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	750,216	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	750,216	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	6,058	
14	80% OF PART B COSTS		
15	SUBTOTAL	744,158	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	744,158	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	678,419	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	65,739	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	4,160,941
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	4,160,941
5	PRIMARY PAYER PAYMENTS	2,769
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	4,199,754

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS 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	4,199,754
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	516,103
21	EXCESS REASONABLE COST	
22	SUBTOTAL	3,683,651
23	COINSURANCE	4,691
24	SUBTOTAL	3,678,960
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	589,873
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	589,873
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	4,268,833
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	4,268,833
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,959,416
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	309,417
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	



		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	7,654,993			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	6,985,196			
5	OTHER RECEIVABLES	31,662			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,468,000			
7	INVENTORY	337,056			
8	PREPAID EXPENSES	349,133			
9	OTHER CURRENT ASSETS	882,219			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	11,772,259			
FIXED ASSETS					
12	LAND	13,981			
12.01					
13	LAND IMPROVEMENTS	1,055,936			
13.01	LESS ACCUMULATED DEPRECIATION	-181,749			
14	BUILDINGS	18,063,150			
14.01	LESS ACCUMULATED DEPRECIATION	-4,958,192			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	6,906,164			
18.01	LESS ACCUMULATED DEPRECIATION	-4,657,474			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	16,241,816			
OTHER ASSETS					
22	INVESTMENTS	1,059,394			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	354,021			
26	TOTAL OTHER ASSETS	1,413,415			
27	TOTAL ASSETS	29,427,490			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,319,139			
29 SALARIES, WAGES & FEES PAYABLE	1,061,808			
30 PAYROLL TAXES PAYABLE	125,251			
31 NOTES AND LOANS PAYABLE (SHORT TERM)	762,018			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	209,364			
36 TOTAL CURRENT LIABILITIES	3,477,580			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	12,427,096			
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	12,427,096			
43 TOTAL LIABILITIES	15,904,676			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	13,522,814			
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	13,522,814			
52 TOTAL LIABILITIES AND FUND BALANCES	29,427,490			

	GENERAL FUND		SPECIFIC PURPOSE FUND
	1	2	3      4
1 FUND BALANCE AT BEGINNING		12,115,726	
2 OF PERIOD			
3 NET INCOME (LOSS)		1,407,088	
4 TOTAL		13,522,814	
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)			
6 ADDITIONS (CREDIT ADJUSTM			
7 CAPITAL GRANTS AND CONTRI			
8			
9			
10 TOTAL ADDITIONS			
11 SUBTOTAL		13,522,814	
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)			
13 DEDUCTIONS (DEBIT ADJUSTM			
14			
15			
16			
17			
18 TOTAL DEDUCTIONS			
19 FUND BALANCE AT END OF		13,522,814	
PERIOD PER BALANCE SHEET			

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

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	2,659,849		2,659,849
4 00 SWING BED - SNF	224,280		224,280
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,884,129		2,884,129
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	2,884,129		2,884,129
17 00 ANCILLARY SERVICES	5,480,904	29,366,617	34,847,521
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC		739,437	739,437
20 00 AMBULANCE SERVICES	34,322	1,650,072	1,684,394
24 00			
25 00 TOTAL PATIENT REVENUES	8,399,355	31,756,126	40,155,481

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		18,950,703	
ADD (SPECIFY)			
27 00 BAD DEBT EXPENSE	2,128,373		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		2,128,373	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		21,079,076	

## STATEMENT OF REVENUES AND EXPENSES

I  
I  
IPROVIDER NO: 14-1323  
I PERIOD: FROM 4/ 1/2010 TO 3/31/2011  
I PREPARED 8/18/2011  
I WORKSHEET G-3  
I

## DESCRIPTION

1	TOTAL PATIENT REVENUES	40,155,481
2	LESS: ALLOWANCES AND DISCOUNTS ON	18,276,190
3	NET PATIENT REVENUES	21,879,291
4	LESS: TOTAL OPERATING EXPENSES	21,079,076
5	NET INCOME FROM SERVICE TO PATIENT	800,215
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	169,546
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	21,432
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	68,030
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	1,396
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	107,000
23	GOVERNMENTAL APPROPRIATIONS	162,641
24	GRANTS AND GIFTS	74,843
24.01	EDUCATION SERVICES	40
24.02	OTHER MISCELLANEOUS INCOME	49,422
25	TOTAL OTHER INCOME	654,350
26	TOTAL	1,454,565
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28	SURG PROFESSIONAL SALARIES	30,497
29	LOSS ON DISPOSAL OF ASSETS	16,980
30	TOTAL OTHER EXPENSES	47,477
31	NET INCOME (OR LOSS) FOR THE PERIO	1,407,088





ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 8/18/2011  
I 14-1323 I FROM 4/ 1/2010 I WORKSHEET M-2  
I COMPONENT NO: I TO 3/31/2011 I  
I 14-3478 I I

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4	
POSITIONS					
1	PHYSICIANS	.57	2,952	4,200	2,394
2	PHYSICIAN ASSISTANTS	.14	1,688	2,100	294
3	NURSE PRACTITIONERS	.75	3,876	2,100	1,575
4	SUBTOTAL (SUM OF LINES 1-3)	1.46	8,516		4,263
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	1.46	8,516		
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)	399,764			
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	399,764			
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000			
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	284,257			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	561,464			
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	845,721			
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	845,721			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	845,721			
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,245,485			
			GREATER OF COL. 2 OR COL. 4 5		
POSITIONS					
1	PHYSICIANS				
2	PHYSICIAN ASSISTANTS				
3	NURSE PRACTITIONERS				
4	SUBTOTAL (SUM OF LINES 1-3)	8,516			
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	8,516			
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

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



TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1,245,485
	(FROM WORKSHEET M-2, LINE 20)	
2	COST OF VACCINES AND THEIR ADMINISTRATION	9,331
	(FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	1,236,154
	(LINE 1 MINUS LINE 2)	
4	TOTAL VISITS	8,516
	(FROM WORKSHEET M-2, COLUMN 5, LINE 8)	
5	PHYSICIANS VISITS UNDER AGREEMENT	
	(FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	8,516
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	145.16

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)	78.82 81.19
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	145.16 145.16
10	CALCULATION OF SETTLEMENT	
	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	987
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	143,273
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)*	143,273
16.01	PRIMARY PAYER AMOUNT	
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	9,022
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	134,251
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	107,401
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	107,401
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	107,401
25	INTERIM PAYMENTS	109,982
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	-2,581
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2	

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

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

COMPUTATION OF PNEUMOCOCCAL AND  
INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 8/18/2011  
I 14-1323 I FROM 4/ 1/2010 I WORKSHEET M-4  
I COMPONENT NO: I TO 3/31/2011 I  
I 14-3478 I I

TITLE XVIII

RHC 1

	PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	147,248	147,248	147,248	147,248
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.005327			.000893
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	784			131
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	784			1,296
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,568			1,427
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	399,764	399,764	399,764	399,764
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	845,721	845,721	845,721	845,721
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.003922			.003570
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	3,317			3,019
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	4,885			4,446
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	14			135
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	348.93			32.93
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES				
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)				
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		9,331		
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)				

RHC 1

DESCRIPTION		P A R T	
		MM/DD/YYYY	B AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1	95,154
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	10/26/2010	14,828
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		14,828
4 TOTAL INTERIM PAYMENTS			109,982
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		2,581
7 TOTAL MEDICARE PROGRAM LIABILITY			107,401

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.