

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 Name

WORKSHEET S PART I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY PROVIDER NO: 50-1300 PERIOD FROM 1/1/2008 TO 12/31/2008 INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE OO - # OF REOPENINGS DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 10/10/2009 TIME 15:20

1 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: GENERAL HOSPITAL 50-1300

FOR THE COST REPORTING PERIOD BEGINNING 1/1/2008 AND ENDING 12/31/2008 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.

2 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

ECR ENCRYPTION INFORMATION DATE: 10/10/2009 TIME 15:20

3 oyBE0mtbqS3EvJP8CGbKacoDePrBx0 NOSEd0VwhfwUUHFFHhrFVI DJL7NM Of9a0Iwg310YgG1K

TITLE

DATE

PI ENCRYPTION INFORMATION DATE: 10/10/2009 TIME 15:20

6bmk1PHYxNOi n0BA1I ohMEvRj ahi v0 Czxtm00MLLqA6: gPe4M8sVe9YJndC MWp24ucSa30uDkwe

PART II - SETTLEMENT SUMMARY 4

Table with columns: TITLE V, Inpatient A, Medicare XVII, Outpatient B, Medicaid XIX, and a final column. Rows include HOSPITAL, SWING BED - SNF, SWING BED - NF, RHC, and TOTAL.

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

PROVIDER NO: 50-1300 PERIOD: FROM 1/1/2008 TO 12/31/2008 PREPARED 10/15/2009 WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 123 COST REPORT RD P.O. BOX: STATE: WA ZIP CODE: 90000- COUNTY: HAPPY

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

Table with columns: COMPONENT, COMPONENT NAME, PROVIDER NO., NPI NUMBER, DATE CERTIFIED, PAYMENT SYSTEM (P, T, O OR N). Rows include HOSPITAL, SWING BED - SNF, SWING BED - NF, and HOSPITAL-BASED RHC.

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/1/2008 TO: 12/31/2008

18 TYPE OF CONTROL

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL SUBPROVIDER

OTHER INFORMATION

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

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N

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

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

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA \$5105 OR MI PPA \$147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO. N

21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MI PPA \$147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) 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. 15-1, 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. 15-1, 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 I ME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS) N N

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

PROVIDER NO: 50-1300 PERIOD: FROM 1/1/2008 TO 12/31/2008 PREPARED 10/15/2009 WORKSHEET S-2

25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR TIME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	N	N		
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			0	
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /			/ /	
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /			/ /	
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y		4/ 1/2002	
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02				
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)		1	2	3 4
			0	0.0000	0.0000
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY		0.00	0	
A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)					
28.03	STAFFING		0.00%		Y/N
28.04	RECRUITMENT		0.00%		
28.05	RETENTION		0.00%		
28.06	TRAINING		0.00%		
28.07			0.00%		
28.08			0.00%		
28.09			0.00%		
28.10			0.00%		
28.11			0.00%		
28.12			0.00%		
28.13			0.00%		
28.14			0.00%		
28.15			0.00%		
28.16			0.00%		
28.17			0.00%		
28.18			0.00%		
28.19			0.00%		
28.20			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	9A DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y			
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N			
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N			
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N			
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE 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)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE 2552-96 20.0.118.2			

V XVIII XIX
1 2 3

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX
IDENTIFICATION DATA

PROVIDER NO: 50-1300
PERIOD: FROM 1/1/2008 TO 12/31/2008
PREPARED 10/15/2009
WORKSHEET S-2

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). 0

MULTI CAMPUS

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
62.01					0.00
62.02					0.00
62.03					0.00
62.04					0.00
62.05					0.00
62.06					0.00
62.07					0.00
62.08					0.00
62.09					0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). Y 9/30/2009 9E

PROVIDER NO: 50-1300 PERIOD: FROM 1/1/2008 TO 12/31/2008 PREPARED 10/10/2009 WORKSHEET S-3 PART I

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

COMPONENT	10	11	12	13A	13B
	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	I/P DAYS / O/P VISITS / NOT LTCH	TRIPS TOTAL
1 ADULTS & PEDIATRICS	25	9,150	7,000.00	1,200	800
2 HMO					
2 01 HMO - (IRF PPS SUBPROVIDER)					
3 ADULTS & PED-SB SNF				1,500	
4 ADULTS & PED-SB NF					1,500
5 TOTAL ADULTS AND PEDS	25	9,150	7,000.00	2,700	2,300
11 NURSERY					
12 TOTAL	25	9,150	7,000.00	2,700	2,300
13 RPCH VISITS					
16 NURSING FACILITY	30	10,500			7,000
16 01 ICF/MR					
18 HOME HEALTH AGENCY					
23 10 CMHC					
24 RURAL HEALTH CLINIC				4,000	
24 10 FOHC					
25 TOTAL	55				10
26 OBSERVATION BED DAYS					
27 AMBULANCE TRIPS					
28 EMPLOYEE DISCOUNT DAYS					
28 01 EMP DISCOUNT DAYS -IRF					

COMPONENT	13C		O/P VISITS TOTAL ALL PATS	13C		7	8
	I/P DAYS / OBSERVATION BEDS ADMITTED	NOT ADMITTED		TRIPS TOTAL OBSERVATION BEDS ADMITTED	NOT ADMITTED		
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			2,000				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			1,600				
4 ADULTS & PED-SB NF			2,000				
5 TOTAL ADULTS AND PEDS			5,600				
11 NURSERY							
12 TOTAL			5,600				
13 RPCH VISITS							
16 NURSING FACILITY			10,000				
16 01 ICF/MR							
18 HOME HEALTH AGENCY							
23 10 CMHC							
24 RURAL HEALTH CLINIC			12,000				
24 10 FOHC							
25 TOTAL							
26 OBSERVATION BED DAYS	14	7	3	50	40	10	
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

Swing SNF days = 1,600
Swing NF days = 2,000
= 3,650 Days to WS D-1, Part I

COMPONENT	16			15		14	15
	I & R FTES NET	FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	DISCHARGES TITLE V	DISCHARGES TITLE XIII		
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					80	10	100
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
11 NURSERY							
12 TOTAL		100.00			80	10	100
13 RPCH VISITS							
16 NURSING FACILITY		20.00					
16 01 ICF/MR							
18 HOME HEALTH AGENCY							
23 10 CMHC							
24 RURAL HEALTH CLINIC		12.00					
24 10 FOHC							
25 TOTAL		132.00					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

Informational

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

PROVIDER NO: 50-1300
 COMPONENT NO: 50-0000
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET S-8

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 123 COST REPORT RD
 1.01 CITY: SMITHSVILLE STATE: WA ZIP CODE: 90000 COUNTY: HAPPY
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	Not Applicable	
	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	Not Applicable	
11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.)		N

FACILITY HOURS OF OPERATIONS (1)

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

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER: TITLE V TITLE XVIII TITLE XIX

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

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET A

Directly from General Ledger

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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		250,000	250,000	50,000	300,000
4 0400	NEW CAP REL COSTS-MVBLE EQUIP		200,000	200,000	40,000	240,000
5 0500	EMPLOYEE BENEFITS	50,000		50,000		1,250,000
6.01 0610	NONPATIENT TELEPHONES			30,000		35,000
6.02 0620	DATA PROCESSING		30,000	30,000		30,000
6.03 0630	PURCHASING, RECEIVING AND STORES	35,000	35,000	70,000		70,000
6.04 0640	ADMITTING	50,000	2,000	52,000		52,000
6.05 0650	CASHIERING/ACCOUNTS RECEIVABLE	200,000	100,000	300,000		300,000
6.06 0660	OTHER ADMINISTRATIVE AND GENERAL	300,000	600,000	900,000	40,000	940,000
7 0700	MAINTENANCE & REPAIRS					
8 0800	OPERATION OF PLANT	150,000	200,000	350,000		350,000
9 0900	LAUNDRY & LINEN SERVICE	25,000	100,000	125,000		125,000
10 1000	HOUSEKEEPING	200,000	30,000	230,000		230,000
11 1100	DIETARY	400,000	300,000	700,000		700,000
12 1200	CAFETERIA					
14 1400	NURSING ADMINISTRATION	200,000	30,000	230,000		230,000
15 1500	CENTRAL SERVICES & SUPPLY					
16 1600	PHARMACY					
17 1700	MEDICAL RECORDS & LIBRARY	100,000	50,000	150,000		150,000
18 1800	SOCIAL SERVICE	50,000	1,000	51,000		51,000
20 2000	NONPHYSICIAN ANESTHETISTS					
21 2100	NURSING SCHOOL					
22 2200	I&R SERVICES-SALARY & FRINGES APPRVD					
23 2300	I&R SERVICES-OTHER PRGM COSTS APPRVD					
24 2400	PARAMED ED PRGM-(SPECIFY)					
INPAT ROUTINE SRVC CNTRS						
25 2500	ADULTS & PEDIATRICS	650,000	100,000	750,000	-50,000	700,000
33 3300	NURSERY		85,000	295,000	20,000	315,000
35 3500	NURSING FACILITY	700,000	200,000	900,000		900,000
35.01 3510	ICF/MR					
ANCILLARY SRVC COST CNTRS						
39 3900	DELIVERY ROOM & LABOR ROOM	250,000	400,000	650,000	30,000	680,000
41 4100	RADIOLOGY-DIAGNOSTIC	200,000	350,000	550,000	-20,000	530,000
44 4400	LABORATORY	200,000	300,000	500,000		500,000
46.30 4650	BLOOD CLOTTING FACTORS ADMIN COSTS					
48 4800	INTRAVENOUS THERAPY	10,000	7,000	17,000		17,000
50 5000	PHYSICAL THERAPY		300,000	300,000		300,000
51 5100	OCCUPATIONAL THERAPY		100,000	100,000		100,000
52 5200	SPEECH PATHOLOGY					
53 5300	ELECTROCARDIOLOGY		30,000	30,000	-20,000	10,000
55 5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,000	15,000	45,000	60,000	105,000
56 5600	DRUGS CHARGED TO PATIENTS	20,000	100,000	120,000		120,000
59 3430	MRI	1,000	100,000	101,000		101,000
OUTPAT SERVICE COST CNTRS						
61 6100	EMERGENCY	550,000	100,000	650,000	-20,000	630,000
62 6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63.50 6310	RURAL HEALTH CLINIC	900,000	150,000	1,050,000	-30,000	1,020,000
63.60 6320	FQHC					
OTHER REIMBURS COST CNTRS						
69.10 6910	CMHC					
71 7100	HOME HEALTH AGENCY					
SPEC PURPOSE COST CENTERS						
85.01 8510	PANCREAS ACQUISITION					
85.02 8520	INTESTINAL ACQUISITION					
88 8800	INTEREST EXPENSE		100,000	100,000	-100,000	
95	SUBTOTALS	5,356,000	5,725,000	11,081,000	-0-	11,081,000
NONREIMBURS COST CENTERS						
100 7950	MEDICAL OFFICE BUILDING	300,000	5,000	305,000		305,000
100.01 7951	GIFT SHOP		1,000	1,000		1,000
100.02 7952	PHYSICIAN OFFICES		5,000	5,000		5,000
100.03 7953	FOUNDATIONS	30,000	10,000	40,000		40,000
101	TOTAL	5,686,000	5,746,000	11,432,000	-0-	11,432,000

Match

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

PROVIDER NO: 50-1300
PERIOD: FROM 1/1/2008 TO 12/31/2008
PREPARED 10/10/2009
WORKSHEET A

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-5,000	295,000
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-4,000	236,000
5	0500 EMPLOYEE BENEFITS		1,250,000
6.01	0610 NONPATIENT TELEPHONES	-5,000	30,000
6.02	0620 DATA PROCESSING		30,000
6.03	0630 PURCHASING, RECEIVING AND STORES	-6,000	64,000
6.04	0640 ADMITTING		52,000
6.05	0650 CASHIERING/ACCOUNTS RECEIVABLE	-3,000	297,000
6.06	0660 OTHER ADMINISTRATIVE AND GENERAL	20,600	960,600
7	0700 MAINTENANCE & REPAIRS		
8	0800 OPERATION OF PLANT		350,000
9	0900 LAUNDRY & LINEN SERVICE		125,000
10	1000 HOUSEKEEPING		230,000
11	1100 DIETARY	-65,000	635,000
12	1200 CAFETERIA		
14	1400 NURSING ADMINISTRATION	-140	229,860
15	1500 CENTRAL SERVICES & SUPPLY		
16	1600 PHARMACY		
17	1700 MEDICAL RECORDS & LIBRARY	-250	149,750
18	1800 SOCIAL SERVICE		51,000
20	2000 NONPHYSICIAN ANESTHETISTS		
21	2100 NURSING SCHOOL		
22	2200 I&R SERVICES-SALARY & FRINGES APPRVD		
23	2300 I&R SERVICES-OTHER PRGM COSTS APPRVD		
24	2400 PARAMED ED PRGM-(SPECIFY) INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-700	699,300
33	3300 NURSERY		315,000
35	3500 NURSING FACILITY	-1,500	898,500
35.01	3510 ICF/MR		
	ANCILLARY SRVC COST CNTRS		
39	3900 DELIVERY ROOM & LABOR ROOM		680,000
41	4100 RADIOLOGY-DIAGNOSTIC	-100,000	430,000
44	4400 LABORATORY	-30,000	470,000
46.30	4650 BLOOD CLOTTING FACTORS ADMIN COSTS		
48	4800 INTRAVENOUS THERAPY		17,000
50	5000 PHYSICAL THERAPY		300,000
51	5100 OCCUPATIONAL THERAPY		100,000
52	5200 SPEECH PATHOLOGY		
53	5300 ELECTROCARDIOLOGY		10,000
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,000	104,000
56	5600 DRUGS CHARGED TO PATIENTS		120,000
59	3430 MRI		101,000
	OUTPAT SERVICE COST CNTRS		
61	6100 EMERGENCY	-100,000	530,000
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63.50	6310 RURAL HEALTH CLINIC	-20,000	1,000,000
63.60	6320 FQHC		
	OTHER REIMBURS COST CNTRS		
69.10	6910 CMHC		
71	7100 HOME HEALTH AGENCY		
	SPEC PURPOSE COST CENTERS		
85.01	8510 PANCREAS ACQUISITION		
85.02	8520 INTESTINAL ACQUISITION		
88	8800 INTEREST EXPENSE		-0-
95	SUBTOTALS	-320,990	10,760,010
	NONREIMBURS COST CENTERS		
100	7950 MEDICAL OFFICE BUILDING	-305,000	
100.01	7951 GIFT SHOP	-1,000	
100.02	7952 PHYSICIAN OFFICES	-5,000	
100.03	7953 FOUNDATIONS	-40,000	
101	TOTAL	-671,990	10,760,010

to WS B, Part I,
in total and by department

RECLASSIFICATIONS

PROVIDER NO:
501300

PERIOD:
FROM 1/ 1/2008
TO 12/31/2008

PREPARED 10/10/2009
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	----- INCREASE -----				
	CODE (1) COST CENTER 1	2	LINE NO 3	SALARY 4	OTHER 5
1 TO RECLASSIFY INTEREST	A	NEW CAP REL COSTS-BLDG & FIXT	3		50,000
2		NEW CAP REL COSTS-MVBLE EQUIP	4		40,000
3		OTHER ADMINISTRATIVE AND GENERAL	6.06		10,000
4 NURSING SALARIES	B	NURSERY	33	20,000	
5		DELIVERY ROOM & LABOR ROOM	39	30,000	
6 CHARGEABLE SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		60,000
7					
8					
9 DIRECTLY ASSIGNED ADMIN DUTIES	D	OTHER ADMINISTRATIVE AND GENERAL	6.06	30,000	
36 TOTAL RECLASSIFICATIONS				80,000	160,000

(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:
501300

PERIOD:
FROM 1/ 1/2008
TO 12/31/2008

PREPARED 10/10/2009
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1) COST CENTER	DECREASE			A-7 REF 10
		LINE NO	SALARY	OTHER	
	1	7	8	9	
1 TO RECLASSIFY INTEREST	A INTEREST EXPENSE	88		100,000	11
2					11
3					11
4 NURSING SALARIES	B ADULTS & PEDIATRICS	25	50,000		
5					
6 CHARGEABLE SUPPLIES	C RADIOLOGY-DIAGNOSTIC	41		20,000	
7	ELECTROCARDIOLOGY	53		20,000	
8	EMERGENCY	61		20,000	
9 DIRECTLY ASSIGNED ADMIN DUTIES	D RURAL HEALTH CLINIC	63.50	30,000		
36 TOTAL RECLASSIFICATIONS			80,000	160,000	

(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: 501300	PERIOD: FROM 1/1/2008 TO 12/31/2008	PREPARED 10/10/2009 WORKSHEET A-6 NOT A CMS WORKSHEET
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RECLASS CODE: A
EXPLANATION : TO RECLASSIFY INTEREST

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	50,000	3		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	40,000	4		
3.00	OTHER ADMINISTRATIVE AND GENER	10,000	6.06		
TOTAL RECLASSIFICATIONS FOR CODE A		100,000		88	INTEREST EXPENSE
					100,000

RECLASS CODE: B
EXPLANATION : NURSING SALARIES

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	NURSERY	20,000	33		
2.00	DELIVERY ROOM & LABOR ROOM	30,000	39		
TOTAL RECLASSIFICATIONS FOR CODE B		50,000		25	ADULTS & PEDIATRICS
					50,000

RECLASS CODE: C
EXPLANATION : CHARGEABLE SUPPLIES

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	60,000	55		
2.00		0		41	RADIOLOGY-DIAGNOSTIC
3.00		0		53	ELECTROCARDIOLOGY
TOTAL RECLASSIFICATIONS FOR CODE C		60,000		61	EMERGENCY
					60,000

RECLASS CODE: D
EXPLANATION : DIRECTLY ASSIGNED ADMIN DUTIES

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	OTHER ADMINISTRATIVE AND GENER	30,000	6.06		
TOTAL RECLASSIFICATIONS FOR CODE D		30,000		63.50	RURAL HEALTH CLINIC
					30,000

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
			DONATION 3					
1 LAND	30,000						30,000	
2 LAND IMPROVEMENTS	60,000	10,000			10,000		70,000	
3 BUILDINGS & FIXTURE	8,500,000	350,000			350,000		8,850,000	
4 BUILDING IMPROVEMEN								
5 FIXED EQUIPMENT	1,000,000	10,000			10,000		1,010,000	
6 MOVABLE EQUIPMENT	2,000,000	150,000			150,000		2,150,000	
7 SUBTOTAL	11,590,000	520,000			520,000		12,110,000	
8 RECONCILING ITEMS								
9 TOTAL	11,590,000	520,000			520,000		12,110,000	

PART III - RECONCILIATION OF CAPITAL COST CENTERS
 DESCRIPTION

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL	
	DESCRIPTION	GROSS ASSETS	CAPITALIZED 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	8,920,000		8,920,000	.805781				
4	NEW CAP REL COSTS-MV	2,150,000		2,150,000	.194219				
5	TOTAL	11,070,000		11,070,000	1.000000				

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	250,000		45,000				295,000
4	NEW CAP REL COSTS-MV	200,000		36,000				236,000
5	TOTAL	450,000		81,000				531,000

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4
 DESCRIPTION SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	250,000						250,000
4	NEW CAP REL COSTS-MV	200,000						200,000
5	TOTAL	450,000						450,000

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

ADJUSTMENTS TO EXPENSES

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO	WKST. A-7 REF. 5
	1	2	3	4	5
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES	B	-5,000	NEW CAP REL COSTS-BLDG &	3	11
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-4,000	NEW CAP REL COSTS-MVBLE E	4	11
5 INVESTMENT INCOME-OTHER	B	-1,000	OTHER ADMINISTRATIVE AND	6.06	
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES	B	-6,000	PURCHASING, RECEIVING AND	6.03	
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS	B	-3,500	OTHER ADMINISTRATIVE AND	6.06	
9 TELEPHONE SERVICES	A	-3,000	NONPATIENT TELEPHONES	6.01	
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-200,700			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	50,000			
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-65,000	DIETARY	11	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHERS					
18 SALE OF MED AND SURG SUPPLIES	B	-1,000	MEDICAL SUPPLIES CHARGED	55	
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-250	MEDICAL RECORDS & LIBRARY	17	
21 NURSG SCHOOL(TUITN, FEES, BOOKS, ETC.)					
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST	B	-3,000	CASHIERING/ACCOUNTS RECEI	6.05	
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**	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					
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	89	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	1	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	2	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-BLDG &	3	
33 NON-PHYSICIAN ANESTHETIST			NEW CAP REL COSTS-MVBLE E	4	
34 PHYSICIANS' ASSISTANT			NONPHYSICIAN ANESTHETISTS	20	
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 PURCHASING REBATES					
38 SNF ACTIVITIES	B	-1,000	NURSING FACILITY	35	
39 LAB MISC. REVENUE	B	-30,000	LABORATORY	44	
40 OTHER ADJUSTMENTS (SPECIFY)					
41 NURSING ADMIN MISC REVENUE	B	-140	NURSING ADMINISTRATION	14	
42 AHA LOBBYING COSTS	A	-700	OTHER ADMINISTRATIVE AND	6.06	
42.10 AWPFD LOBBYING COSTS	A	-500	OTHER ADMINISTRATIVE AND	6.06	
43 NH FUNDRAISING	A	-500	NURSING FACILITY	35	
44 BONUS PAYBACK					
45 NONALLOWABLE RHC PHYSICIAN DUTI	A	-20,000	RURAL HEALTH CLINIC	63.50	
46 WSHA LOBBYING COSTS	A	-3,000	OTHER ADMINISTRATIVE AND	6.06	
47 PATIENT TELEPHONE SALARY EXPENS	A	-2,000	NONPATIENT TELEPHONES	6.01	
48 FOUNDATION SALARIES AND OTHER EXPENS	A	-20,000	OTHER ADMINISTRATIVE AND	6.06	
49 HEALTH DISTRICT REIMBURSEMENTS					
49.10 MEDICAL OFFICE BUILDING	A	-305,000	MEDICAL OFFICE BUILDING	100	
49.20 STALE DATED WARRANTS	B	-500	OTHER ADMINISTRATIVE AND	6.06	
49.30 GIFT SHOP	A	-1,000	GIFT SHOP	100.01	
49.40 PHYSICIAN OFFICES	A	-5,000	PHYSICIAN OFFICES	100.02	
49.41 OTHER SETTLEMENTS	B	-200	OTHER ADMINISTRATIVE AND	6.06	
49.50 FOUNDATION	A	-40,000	FOUNDATIONS	100.03	
50 TOTAL (SUM OF LINES 1 THRU 49)		-671,990			

Agrees to WS A, Column 6

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	OTHER ADMINISTRATIVE AND TREASURER COST	25,000		25,000	
2	6	OTHER ADMINISTRATIVE AND MANAGEMENT FEES		25,000	-25,000	
3	6	OTHER ADMINISTRATIVE AND VARIOUS MANAGEMENT EXPS	50,000		50,000	
4						
5		TOTALS	75,000	25,000	50,000	

Agrees to WS A-8, Line 14

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
1	G	HAPPY COUNTY TREASURER	100.00	COUNTY TREASURER	0.00	COUNTY TREASURER
2	A	HAPPY MANAGERS	0.00	HAPPY HOSPITAL CONSULTANT	0.00	HOSPITAL CONSULTANTS
3			0.00		0.00	
4			0.00		0.00	
5			0.00		0.00	

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET A-8-2
 GROUP 1

LINE NO.	WKSHT A 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	Total TOTAL REMUN- ERATION 3	Part B 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	61	EMERGENCY	450,000	100,000	350,000				
2	41	RADIOLOGY	100,000	100,000					
3	25	HOSPITALIST	700	700					
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	550,700	200,700	350,000				

Agrees to WS A-8, Line 12

PROVIDER BASED PHYSICIAN ADJUSTMENTS

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET A-8-2
 GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	61 EMERGENCY							100,000
2	41 RADIOLOGY							100,000
3	25 HOSPITALIST							700
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL							200,700

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

I PROVIDER NO: I PERIOD: I PREPARED 10/10/2009
 I 50-1300 I FROM 1/ 1/2008 I WORKSHEET A-8-4
 I I TO 12/31/2008 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52				
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780				
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	200				
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)					
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)					
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)					
7	STANDARD TRAVEL EXPENSE RATE	5.00				
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	.50				
			SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES
			1	2	3	4
9	TOTAL HOURS WORKED			2000.00	2000.00	1500.00
10	AHSEA (SEE INSTRUCTIONS)			60.00	50.00	20.00
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	30.00		30.00	25.00	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	120,000
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	100,000
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	220,000
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	30,000
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	250,000

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	250,000

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

STANDARD TRAVEL ALLOWANCE	
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)

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

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET A-8-4
 PARTS I - VII

PHYSICAL THERAPY

- 31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
- 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2,
LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
- 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 7,000
- 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
- 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

- 57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 250,000
- 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 7,000
- 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
- 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)

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

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET A-8-4
 PARTS I - VII

PHYSICAL THERAPY

61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	257,000
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	250,000
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

Agrees to WS A-8, Line 26

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	250,000
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.11	COST OF OUTSIDE SUPPLIER SERVICES - CMHC I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.21	COST OF OUTSIDE SUPPLIER SERVICES - OPT I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.41	COST OF OUTSIDE SUPPLIER SERVICES - OOT I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.51	COST OF OUTSIDE SUPPLIER SERVICES - OSP I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	250,000
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.11	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CMHC I (LINE 66 DIVIDED BY LINE 67)	
68.21	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OPT I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
68.41	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OOT I (LINE 66 DIVIDED BY LINE 67)	
68.51	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OSP I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.11	EXCESS COST OVER LIMITATION-CMHC I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.21	EXCESS COST OVER LIMITATION- OPT I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.41	EXCESS COST OVER LIMITATION- OOT I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.51	EXCESS COST OVER LIMITATION- OSP I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE WITH LINE 65)	

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

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET A-8-4
 PARTS I - VII

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52				
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780				
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	150				
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)					
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)					
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)					
7	STANDARD TRAVEL EXPENSE RATE	5.00				
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	.50				
			SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4
9	TOTAL HOURS WORKED			1600.00		
10	AHSEA (SEE INSTRUCTIONS)			60.00		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	30.00		30.00		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	96,000
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	96,000
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	96,000

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	96,000

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	4,500
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	4,500
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	750
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	5,250
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	

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

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET A-8-4
 PARTS I - VII

OCCUPATIONAL THERAPY

31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2,
 LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 5,250
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 96,000
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 5,250
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)

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

PROVIDER NO: 50-1300
PERIOD: FROM 1/1/2008 TO 12/31/2008
PREPARED 10/10/2009
WORKSHEET A-8-4
PARTS I - VII

OCCUPATIONAL THERAPY

61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	101,250
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	100,000
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	100,000
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.11	COST OF OUTSIDE SUPPLIER SERVICES - CMHC I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.21	COST OF OUTSIDE SUPPLIER SERVICES - OPT I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.41	COST OF OUTSIDE SUPPLIER SERVICES - OOT I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.51	COST OF OUTSIDE SUPPLIER SERVICES - OSP I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	100,000
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.11	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CMHC I (LINE 66 DIVIDED BY LINE 67)	
68.21	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OPT I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
68.41	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OOT I (LINE 66 DIVIDED BY LINE 67)	
68.51	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OSP I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.11	EXCESS COST OVER LIMITATION-CMHC I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.21	EXCESS COST OVER LIMITATION- OPT I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.41	EXCESS COST OVER LIMITATION- OOT I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.51	EXCESS COST OVER LIMITATION- OSP I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE WITH LINE 65)	

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

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET A-8-4
 PARTS I - VII

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

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

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

- 9 TOTAL HOURS WORKED
- 10 AHSEA (SEE INSTRUCTIONS)
- 11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)
- 12 NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)
- 12.01 NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)
- 13 NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)
- 13.01 NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

- STANDARD TRAVEL ALLOWANCE
- 24 THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)
- 25 ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)
- 26 SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)
- 27 STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)
- 28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)
- OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE
- 29 THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)
- 30 ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)

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

PROVIDER NO: 50-1300
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 WORKSHEET A-8-4
 PARTS I - VII

SPEECH PATHOLOGY

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

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

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
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 WORKSHEET A-8-4
 PARTS I - VII

SPEECH PATHOLOGY

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

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

- 66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)
- 66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)
- 66.11 COST OF OUTSIDE SUPPLIER SERVICES - CMHC I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)
- 66.21 COST OF OUTSIDE SUPPLIER SERVICES - OPT I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)
- 66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)
- 66.41 COST OF OUTSIDE SUPPLIER SERVICES - OOT I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)
- 66.51 COST OF OUTSIDE SUPPLIER SERVICES - OSP I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)
- 67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)
- 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)
- 68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)
- 68.11 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CMHC I (LINE 66 DIVIDED BY LINE 67)
- 68.21 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OPT I (LINE 66 DIVIDED BY LINE 67)
- 68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)
- 68.41 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OOT I (LINE 66 DIVIDED BY LINE 67)
- 68.51 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- OSP I (LINE 66 DIVIDED BY LINE 67)
- 69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
- 69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
- 69.11 EXCESS COST OVER LIMITATION-CMHC I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
- 69.21 EXCESS COST OVER LIMITATION- OPT I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
- 69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
- 69.41 EXCESS COST OVER LIMITATION- OOT I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
- 69.51 EXCESS COST OVER LIMITATION- OSP I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
- 70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE WITH LINE 65)

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	EMPLOYEE BENEFITS 5	NONPATIENT TELEPHONES 6.01	DATA PROCESSING 6.02	PURCHASING, RECEIVING AND 6.03
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	295,000	295,000					
005 NEW CAP REL COSTS-MVBLE E	236,000		236,000				
006 EMPLOYEE BENEFITS	1,250,000	3,398		1,253,398			
006 01 NONPATIENT TELEPHONES	30,000		2,922		32,922		
006 02 DATA PROCESSING	30,000					30,000	
006 03 PURCHASING, RECEIVING AND	64,000	+	0	+	7,784	+	0
006 04 ADMINITTING	52,000				11,120		73,203
006 05 CASHIERING/ACCOUNTS RECEI	297,000	9,060	14,023	44,478	2,838		347
006 06 OTHER ADMINISTRATIVE AND	960,600	15,855	75,961	73,389	5,677	15,000	1,909
007 MAINTENANCE & REPAIRS							3,472
008 OPERATION OF PLANT	350,000	9,060	17,529	33,359	1,419		7,811
009 LAUNDRY & LINEN SERVICE	125,000		292	5,560			521
010 HOUSEKEEPING	230,000	4,530	58	44,478			5,207
011 DIETARY	635,000	4,530	2,337	88,956	1,419		
012 CAFETERIA		13,590					
014 NURSING ADMINISTRATION	229,860	4,530	1,169	44,478	1,419	600	174
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY	149,750	3,624	1,753	22,239	2,838	6,000	868
018 SOCIAL SERVICE	51,000	340		11,120	1,419	600	3
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMEDICAL PRGM-(SPECIFY)							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	699,300	22,650	14,023	133,435	1,419		10,416
033 NURSERY	315,000	5,436	4,674	23,351	284		4,340
035 NURSING FACILITY	898,500	45,301	5,843	155,674	1,419		8,679
035 01 ICF/MR							
ANCILLARY SRVC COST CNTRS							
039 DELIVERY ROOM & LABOR ROO	680,000			62,269			
041 RADIOLOGY-DIAGNOSTIC	430,000	9,060	75,959	44,478	1,419	1,200	8,679
044 LABORATORY	470,000	3,171	5,843	44,478	1,419	1,200	
046 30 BLOOD CLOTTING FACTORS AD							
048 INTRAVENOUS THERAPY	17,000			2,224			347
050 PHYSICAL THERAPY	300,000	11,325	2,337		1,419	600	1,215
051 OCCUPATIONAL THERAPY	100,000						122
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY	10,000	113					694
055 MEDICAL SUPPLIES CHARGED	104,000	9,060		6,672			2,604
056 DRUGS CHARGED TO PATIENTS	120,000	317		4,448			
059 MRI	101,000			222			
061 OUTPAT SERVICE COST CNTRS							
061 EMERGENCY	530,000	18,120	1,753	122,315	2,838	1,200	5,207
062 OBSERVATION BEDS (NON-DIS							
063 50 RURAL HEALTH CLINIC	1,000,000	31,711	3,506	193,482	2,838	3,000	9,547
063 60 FQHC							
069 10 OTHER REIMBURS COST CNTRS							
071 CMHC							
071 HOME HEALTH AGENCY							
SPEC PURPOSE COST CENTERS							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITION							
095 SUBTOTALS	10,760,010	227,046	230,157	1,180,009	31,503	29,400	72,162
NONREIMBURS COST CENTERS							
100 MEDICAL OFFICE BUILDING		67,954	5,843	66,717	1,419	600	1,041
100 01 GIFT SHOP							
100 02 PHYSICIAN OFFICES							
100 03 FOUNDATIONS				6,672			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	10,760,010	295,000	236,000	1,253,398	32,922	30,000	73,203

Net expenses by department and in total from WS A, Column 7

Total = \$531,000 to WS B, Part III

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	ADMITTING	CASHIERING/AC COUNTS RECEI	SUBTOTAL	OTHER ADMINIS TRATIVE AND	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE
	6.04	6.05	6a.05	6.06	7	8	9
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING, RECEIVING AND							
006 04 ADMITTING	65,907						
006 05 CASHIERING/ACCOUNTS RECEI		369,308					
006 06 OTHER ADMINISTRATIVE AND			1,149,954	1,149,954			
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT			419,178	50,160		469,338	
009 LAUNDRY & LINEN SERVICE			131,373	15,720			147,093
010 HOUSEKEEPING			284,273	34,017		8,326	12,536
011 DIETARY			732,242	87,622		8,326	1,672
012 CAFETERIA			13,590	1,626		24,978	
014 NURSING ADMINISTRATION			282,230	33,772		8,326	
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY			187,072	22,385		6,661	
018 SOCIAL SERVICE			64,482	7,716		624	
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM-(SPECIFY)							
025 INPAT ROUTINE SRVC CNTRS							
033 ADULTS & PEDIATRICS	58,584	46,866	986,693	118,070		41,630	29,251
035 NURSERY		10,935	364,020	43,559		9,991	8,358
035 01 NURSING FACILITY	1,465	42,179	1,159,060	138,695		83,260	66,859
039 ANCILLARY SRVC COST CNTRS							
041 DELIVERY ROOM & LABOR ROO		10,935	753,204	90,130			8,358
044 RADIOLOGY-DIAGNOSTIC		23,433	594,228	71,107		16,652	4,179
046 LABORATORY		39,055	565,166	67,629		5,828	
048 30 BLOOD CLOTTING FACTORS AD							
050 INTRAVENOUS THERAPY		6,249	25,820	3,090			
051 PHYSICAL THERAPY		15,622	332,518	39,790		20,815	4,597
052 OCCUPATIONAL THERAPY		6,249	106,371	12,729			
053 SPEECH PATHOLOGY							
055 ELECTROCARDIOLOGY		2,187	12,994	1,555		208	
056 MEDICAL SUPPLIES CHARGED		3,124	125,460	15,013		16,652	
059 DRUGS CHARGED TO PATIENTS		12,498	137,263	16,425		583	
061 MRI		15,622	116,844	13,982			
062 OUTPAT SERVICE COST CNTRS							
063 EMERGENCY		62,493	743,926	89,020		33,304	4,179
063 50 OBSERVATION BEDS (NON-DIS							
063 60 RURAL HEALTH CLINIC		46,866	1,290,950	154,472		58,282	418
069 10 FQHC							
071 OTHER REIMBURS COST CNTRS							
085 01 CMHC							
085 02 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS							
100 01 PANCREAS ACQUISITION							
100 02 INTESTINAL ACQUISITION							
100 03 SUBTOTALS	60,049	344,313	10,578,911	1,128,284		344,446	140,407
100 NONREIMBURS COST CENTERS							
100 01 MEDICAL OFFICE BUILDING	5,858	24,995	174,427	20,872		124,892	6,686
100 02 GIFT SHOP							
100 03 PHYSICIAN OFFICES							
101 FOUNDATIONS			6,672	798			
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
TOTAL	65,907	369,308	10,760,010	1,149,954		469,338	147,093

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
	10	11	12	14	15	16	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING, RECEIVING AND							
006 04 ADMITTING							
006 05 CASHIERING/ACCOUNTS RECEI							
006 06 OTHER ADMINISTRATIVE AND							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	339,152						
011 DIETARY	27,499	857,361					
012 CAFETERIA		196,902	237,096				
014 NURSING ADMINISTRATION			9,150	333,478			
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY	5,500		11,437				233,055
018 SOCIAL SERVICE			2,287	4,264			
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM-(SPECIFY)							
025 INPAT ROUTINE SRVC CNTRS							
033 ADULTS & PEDIATRICS	91,661	118,141	45,751	85,290			22,961
035 NURSERY	22,916		11,437	21,322			2,296
035 01 NURSING FACILITY	91,663	295,353	45,749	85,288			2,296
039 ANCILLARY SRVC COST CNTRS							
041 DELIVERY ROOM & LABOR ROO	18,333		11,437	21,322			3,444
044 RADIOLOGY-DIAGNOSTIC	9,166		22,875				13,777
046 LABORATORY	9,166		11,437				18,369
048 30 BLOOD CLOTTING FACTORS AD							
050 INTRAVENOUS THERAPY			343	853			
051 PHYSICAL THERAPY	3,667						4,592
052 OCCUPATIONAL THERAPY							
053 SPEECH PATHOLOGY							
055 ELECTROCARDIOLOGY			572				
056 MEDICAL SUPPLIES CHARGED			2,287				
059 DRUGS CHARGED TO PATIENTS			572				
061 MRI							
062 OUTPAT SERVICE COST CNTRS							
063 EMERGENCY	18,333	837	16,012	19,190			68,883
063 50 OBSERVATION BEDS (NON-DIS							
063 60 RURAL HEALTH CLINIC	4,583		22,875	53,305			91,845
069 FQHC							
071 OTHER REIMBURS COST CNTRS							
085 10 CMHC							
085 01 HOME HEALTH AGENCY							
085 02 SPEC PURPOSE COST CENTERS							
095 PANCREAS ACQUISITION							
095 02 INTESTINAL ACQUISITION							
100 SUBTOTALS	302,487	611,233	214,221	290,834			228,463
100 NONREIMBURS COST CENTERS							
100 01 MEDICAL OFFICE BUILDING	36,665	246,128	22,875	42,644			4,592
100 02 GIFT SHOP							
100 03 PHYSICIAN OFFICES							
101 FOUNDATIONS							
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
TOTAL	339,152	857,361	237,096	333,478			233,055

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES-SALARY & FRI	I&R SERVICES-OTHER PRGM C	PARAMED ED PRGM-(SPECIFY)	SUBTOTAL
	18	20	21	22	23	24	25
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING, RECEIVING AND							
006 04 ADMITTING							
006 05 CASHIERING/ACCOUNTS RECEI							
006 06 OTHER ADMINISTRATIVE AND							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA							
014 NURSING ADMINISTRATION							
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY							
018 SOCIAL SERVICE	79,373						
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM-(SPECIFY)							
025 INPAT ROUTINE SRVC CNTRS							
033 ADULTS & PEDIATRICS	22,678						1,562,126
035 NURSERY							483,899
035 01 NURSING FACILITY	56,695						2,024,918
035 01 ICF/MR							
039 ANCILLARY SRVC COST CNTRS							
041 DELIVERY ROOM & LABOR ROO							906,228
044 RADIOLOGY-DIAGNOSTIC							731,984
044 LABORATORY							677,595
046 30 BLOOD CLOTTING FACTORS AD							
048 INTRAVENOUS THERAPY							30,106
050 PHYSICAL THERAPY							405,979
051 OCCUPATIONAL THERAPY							119,100
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY							15,329
055 MEDICAL SUPPLIES CHARGED							159,412
056 DRUGS CHARGED TO PATIENTS							154,843
059 MRI							130,826
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY							993,684
062 OBSERVATION BEDS (NON-DIS							
063 50 RURAL HEALTH CLINIC							1,676,730
063 60 FQHC							
069 10 OTHER REIMBURS COST CNTRS							
071 CMHC							
071 HOME HEALTH AGENCY							
085 01 SPEC PURPOSE COST CENTERS							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITION							
095 SUBTOTALS	79,373						10,072,759
100 NONREIMBURS COST CENTERS							
100 MEDICAL OFFICE BUILDING							679,781
100 01 GIFT SHOP							
100 02 PHYSICIAN OFFICES							
100 03 FOUNDATIONS							7,470
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	79,373						10,760,010

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	I&R COST POST STEP-DOWN ADJ 26	TOTAL
003 GENERAL SERVICE COST CNTR		
004 NEW CAP REL COSTS-BLDG &		
005 NEW CAP REL COSTS-MVBLE E		
006 EMPLOYEE BENEFITS		
006 01 NONPATIENT TELEPHONES		
006 02 DATA PROCESSING		
006 03 PURCHASING, RECEIVING AND		
006 04 ADMITTING		
006 05 CASHIERING/ACCOUNTS RECEI		
006 06 OTHER ADMINISTRATIVE AND		
007 MAINTENANCE & REPAIRS		
008 OPERATION OF PLANT		
009 LAUNDRY & LINEN SERVICE		
010 HOUSEKEEPING		
011 DIETARY		
012 CAFETERIA		
014 NURSING ADMINISTRATION		
015 CENTRAL SERVICES & SUPPLY		
016 PHARMACY		
017 MEDICAL RECORDS & LIBRARY		
018 SOCIAL SERVICE		
020 NONPHYSICIAN ANESTHETISTS		
021 NURSING SCHOOL		
022 I&R SERVICES-SALARY & FRI		
023 I&R SERVICES-OTHER PRGM C		
024 PARAMED ED PRGM-(SPECIFY)		
024 INPAT ROUTINE SRVC CNTRS		
025 ADULTS & PEDIATRICS	to WS D-1	1,562,126
033 NURSERY		483,899
035 NURSING FACILITY		2,024,918
035 01 ICF/MR		
039 ANCILLARY SRVC COST CNTRS		
041 DELIVERY ROOM & LABOR ROO		906,228
044 RADIOLOGY-DIAGNOSTIC		731,984
044 LABORATORY		677,595
046 30 BLOOD CLOTTING FACTORS AD		
048 INTRAVENOUS THERAPY		30,106
050 PHYSICAL THERAPY		405,979
051 OCCUPATIONAL THERAPY		119,100
052 SPEECH PATHOLOGY		
053 ELECTROCARDIOLOGY		15,329
055 MEDICAL SUPPLIES CHARGED		159,412
056 DRUGS CHARGED TO PATIENTS		154,843
059 MRI		130,826
061 OUTPAT SERVICE COST CNTRS		
061 EMERGENCY		993,684
062 OBSERVATION BEDS (NON-DIS		
063 50 RURAL HEALTH CLINIC		1,676,730
063 60 FQHC		
069 10 OTHER REIMBURS COST CNTRS		
071 CMHC		
071 HOME HEALTH AGENCY		
085 SPEC PURPOSE COST CENTERS		
085 01 PANCREAS ACQUISITION		
085 02 INTESTINAL ACQUISITION		
095 SUBTOTALS		10,072,759
095 NONREIMBURS COST CENTERS		
100 MEDICAL OFFICE BUILDING		679,781
100 01 GIFT SHOP		
100 02 PHYSICIAN OFFICES		
100 03 FOUNDATIONS		7,470
101 CROSS FOOT ADJUSTMENT		
102 NEGATIVE COST CENTER		
103 TOTAL		10,760,010

Fully loaded costs



to WS C, Part I (excludes observation)

WS A, Column 7 &
WS B, Part I, Column 0 (in total)

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET B PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	NONPATIENT TELEPHONES 6.01	DATA PROCESSING 6.02
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS		3,398		3,398	3,398		
006 01 NONPATIENT TELEPHONES			2,922	2,922		2,922	
006 02 DATA PROCESSING							
006 03 PURCHASING, RECEIVING AND							126
006 04 ADMITTING		2,265	175	2,440	30		
006 05 CASHIERING/ACCOUNTS RECEI		9,060	14,023	23,083	121		252
006 06 OTHER ADMINISTRATIVE AND		15,855	75,961	91,816	199		503
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT		9,060	17,529	26,589	90		126
009 LAUNDRY & LINEN SERVICE			292	292	15		
010 HOUSEKEEPING		4,530	58	4,588	121		
011 DIETARY		4,530	2,337	6,867	241		126
012 CAFETERIA		13,590		13,590			
014 NURSING ADMINISTRATION		4,530	1,169	5,699	121		126
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		3,624	1,753	5,377	60		252
018 SOCIAL SERVICE		340		340	30		126
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM-(SPECIFY)							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		22,650	14,023	36,673	362		126
033 NURSERY		5,436	4,674	10,110	63		25
035 NURSING FACILITY		45,301	5,843	51,144	422		126
035 01 ICF/MR							
039 ANCILLARY SRVC COST CNTRS							
041 DELIVERY ROOM & LABOR ROO						169	
044 RADIOLOGY-DIAGNOSTIC		9,060	75,959	85,019	121		126
046 LABORATORY		3,171	5,843	9,014	121		126
046 30 BLOOD CLOTTING FACTORS AD							
048 INTRAVENOUS THERAPY						6	
050 PHYSICAL THERAPY		11,325	2,337	13,662			126
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY		113		113			
055 MEDICAL SUPPLIES CHARGED		9,060		9,060	18		
056 DRUGS CHARGED TO PATIENTS		317		317	12		
059 MRI					1		
061 OUTPAT SERVICE COST CNTRS							
061 EMERGENCY		18,120	1,753	19,873	332		252
062 OBSERVATION BEDS (NON-DIS							
063 50 RURAL HEALTH CLINIC		31,711	3,506	35,217	523		252
063 60 FQHC							
069 OTHER REIMBURS COST CNTRS							
069 10 CMHC							
071 HOME HEALTH AGENCY							
085 SPEC PURPOSE COST CENTERS							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITION							
095 SUBTOTALS		227,046	230,157	457,203	3,199		2,796
100 NONREIMBURS COST CENTERS							
100 MEDICAL OFFICE BUILDING		67,954	5,843	73,797	181		126
100 01 GIFT SHOP							
100 02 PHYSICIAN OFFICES							
100 03 FOUNDATIONS					18		
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		295,000	236,000	531,000	3,398		2,922

from WS B, Part I

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	PURCHASING, RECEIVING AND	ADMITTING	CASHIERING/ACCOUNTS RECEI	OTHER ADMINISTRATIVE AND	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
	6.03	6.04	6.05	6.06	7	8	9
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING, RECEIVING AND	147						
006 04 ADMITTING	1	2,471					
006 05 CASHIERING/ACCOUNTS RECEI	4		23,460				
006 06 OTHER ADMINISTRATIVE AND	7			92,525			
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT	16			4,036		30,857	
009 LAUNDRY & LINEN SERVICE	1			1,265			1,573
010 HOUSEKEEPING	10			2,737		547	134
011 DIETARY				7,050		547	18
012 CAFETERIA				131		1,642	
014 NURSING ADMINISTRATION				2,717		547	
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY	2			1,801		438	
018 SOCIAL SERVICE				621		41	
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM-(SPECIFY)							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	23	2,196	2,978	9,500		2,737	313
033 NURSERY	9		695	3,505		657	89
035 NURSING FACILITY	17	55	2,680	11,159		5,474	715
035 01 ICF/MR							
039 ANCILLARY SRVC COST CNTRS							
041 DELIVERY ROOM & LABOR ROO			695	7,252			89
044 RADIOLOGY-DIAGNOSTIC	17		1,489	5,721		1,095	45
044 LABORATORY			2,481	5,441		383	
046 30 BLOOD CLOTTING FACTORS AD							
048 INTRAVENOUS THERAPY	1		397	249			
050 PHYSICAL THERAPY	2		993	3,201		1,369	49
051 OCCUPATIONAL THERAPY			397	1,024			
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY	1		139	125		14	
055 MEDICAL SUPPLIES CHARGED	5		199	1,208		1,095	
056 DRUGS CHARGED TO PATIENTS			794	1,322		38	
059 MRI			993	1,125			
061 OUTPAT SERVICE COST CNTRS							
061 EMERGENCY	10		3,964	7,163		2,190	45
062 OBSERVATION BEDS (NON-DIS							
063 50 RURAL HEALTH CLINIC	19		2,978	12,429		3,832	4
063 60 FQHC							
069 10 OTHER REIMBURS COST CNTRS							
071 CMHC							
071 HOME HEALTH AGENCY							
071 SPEC PURPOSE COST CENTERS							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITION							
095 SUBTOTALS	145	2,251	21,872	90,782		22,646	1,501
NONREIMBURS COST CENTERS							
100 MEDICAL OFFICE BUILDING	2	220	1,588	1,679		8,211	72
100 01 GIFT SHOP							
100 02 PHYSICIAN OFFICES							
100 03 FOUNDATIONS				64			
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	147	2,471	23,460	92,525		30,857	1,573

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINISTRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING, RECEIVING AND							
006 04 ADMITTING							
006 05 CASHIERING/ACCOUNTS RECEI							
006 06 OTHER ADMINISTRATIVE AND							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	8,137						
011 DIETARY	660	15,509					
012 CAFETERIA		3,562	18,925				
014 NURSING ADMINISTRATION			730	9,940			
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY	132		913				8,975
018 SOCIAL SERVICE			183	127			
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM-(SPECFY)							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	2,198	2,137	3,650	2,542			884
033 NURSERY	550		913	636			88
035 NURSING FACILITY	2,199	5,343	3,652	2,542			88
035 01 ICF/MR							
039 ANCILLARY SRVC COST CNTRS							
041 DELIVERY ROOM & LABOR ROO	440		913	636			133
044 RADIOLOGY-DIAGNOSTIC	220		1,826				531
044 LABORATORY	220		913				707
046 30 BLOOD CLOTTING FACTORS AD							
048 INTRAVENOUS THERAPY			27	25			
050 PHYSICAL THERAPY	88						177
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY			46				
055 MEDICAL SUPPLIES CHARGED			183				
056 DRUGS CHARGED TO PATIENTS			46				
059 MRI							
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	440	15	1,278	572			2,653
062 OBSERVATION BEDS (NON-DIS							
063 50 RURAL HEALTH CLINIC	110		1,826	1,589			3,537
063 60 FOHC							
069 OTHER REIMBURS COST CNTRS							
071 10 CMHC							
071 HOME HEALTH AGENCY							
085 SPEC PURPOSE COST CENTERS							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITION							
095 SUBTOTALS	7,257	11,057	17,099	8,669			8,798
NONREIMBURS COST CENTERS							
100 MEDICAL OFFICE BUILDING	880	4,452	1,826	1,271			177
100 01 GIFT SHOP							
100 02 PHYSICIAN OFFICES							
100 03 FOUNDATIONS							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	8,137	15,509	18,925	9,940			8,975

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES-SALARY & FRI	I&R SERVICES-OTHER PRGM C	PARAMED ED PRGM-(SPECIFY)	SUBTOTAL
	18	20	21	22	23	24	25
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING, RECEIVING AND							
006 04 ADMITTING							
006 05 CASHIERING/ACCOUNTS RECEI							
006 06 OTHER ADMINISTRATIVE AND							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA							
014 NURSING ADMINISTRATION							
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY							
018 SOCIAL SERVICE	1,468						
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM-(SPECIFY)							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	419						66,738
033 NURSERY							17,340
035 NURSING FACILITY	1,049						86,665
035 01 ICF/MR							
039 ANCILLARY SRVC COST CNTRS							
041 DELIVERY ROOM & LABOR ROO							10,327
044 RADIOLOGY-DIAGNOSTIC							96,210
044 LABORATORY							19,406
046 30 BLOOD CLOTTING FACTORS AD							
048 INTRAVENOUS THERAPY							705
050 PHYSICAL THERAPY							19,667
051 OCCUPATIONAL THERAPY							1,421
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY							438
055 MEDICAL SUPPLIES CHARGED							11,768
056 DRUGS CHARGED TO PATIENTS							2,529
059 MRI							2,119
061 OUTPAT SERVICE COST CNTRS							
061 EMERGENCY							38,787
062 OBSERVATION BEDS (NON-DIS							
063 50 RURAL HEALTH CLINIC							62,316
063 60 FQHC							
069 10 OTHER REIMBURS COST CNTRS							
071 CMHC							
071 HOME HEALTH AGENCY							
071 SPEC PURPOSE COST CENTERS							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITION							
095 SUBTOTALS	1,468						436,436
095 NONREIMBURS COST CENTERS							
100 MEDICAL OFFICE BUILDING							94,482
100 01 GIFT SHOP							
100 02 PHYSICIAN OFFICES							
100 03 FOUNDATIONS							82
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	1,468						531,000

ALLOCATION OF NEW CAPITAL RELATED COSTS

	POST STEPDOWN ADJUSTMENT	TOTAL
	26	27
003	GENERAL SERVICE COST CNTR	
004	NEW CAP REL COSTS-BLDG &	
005	NEW CAP REL COSTS-MVBLE E	
006	EMPLOYEE BENEFITS	
006	01 NONPATIENT TELEPHONES	
006	02 DATA PROCESSING	
006	03 PURCHASING, RECEIVING AND	
006	04 ADMITTING	
006	05 CASHIERING/ACCOUNTS RECEI	
006	06 OTHER ADMINISTRATIVE AND	
007	MAINTENANCE & REPAIRS	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATION	
015	CENTRAL SERVICES & SUPPLY	
016	PHARMACY	
017	MEDICAL RECORDS & LIBRARY	
018	SOCIAL SERVICE	
020	NONPHYSICIAN ANESTHETISTS	
021	NURSING SCHOOL	
022	I&R SERVICES-SALARY & FRI	
023	I&R SERVICES-OTHER PRGM C	
024	PARAMED ED PRGM-(SPECIFY)	
	INPAT ROUTINE SRVC CNTRS	
025	ADULTS & PEDIATRICS	66,738
033	NURSERY	17,340
035	NURSING FACILITY	86,665
035	01 ICF/MR	
	ANCILLARY SRVC COST CNTRS	
039	DELIVERY ROOM & LABOR ROO	10,327
041	RADIOLOGY-DIAGNOSTIC	96,210
044	LABORATORY	19,406
046	30 BLOOD CLOTTING FACTORS AD	
048	INTRAVENOUS THERAPY	705
050	PHYSICAL THERAPY	19,667
051	OCCUPATIONAL THERAPY	1,421
052	SPEECH PATHOLOGY	
053	ELECTROCARDIOLOGY	438
055	MEDICAL SUPPLIES CHARGED	11,768
056	DRUGS CHARGED TO PATIENTS	2,529
059	MRI	2,119
	OUTPAT SERVICE COST CNTRS	
061	EMERGENCY	38,787
062	OBSERVATION BEDS (NON-DIS	
063	50 RURAL HEALTH CLINIC	62,316
063	60 FQHC	
	OTHER REIMBURS COST CNTRS	
069	10 CMHC	
071	HOME HEALTH AGENCY	
	SPEC PURPOSE COST CENTERS	
085	01 PANCREAS ACQUISITION	
085	02 INTESTINAL ACQUISITION	
095	SUBTOTALS	436,436
	NONREIMBURS COST CENTERS	
100	MEDICAL OFFICE BUILDING	94,482
100	01 GIFT SHOP	
100	02 PHYSICIAN OFFICES	
100	03 FOUNDATIONS	82
101	CROSS FOOT ADJUSTMENTS	
102	NEGATIVE COST CENTER	
103	TOTAL	531,000

COST ALLOCATION - STATISTICAL BASIS

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	NONPATIENT TELEPHONES (NON PATIENT)	DATA PROCESSING (# TERMINALS)	PURCHASING, RECEIVING AND (SUPPLIES EXPENSE)
	3	4	5	6.01	6.02	6.03
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	B 65,120					
005 NEW CAP REL COSTS-MVB		201,950				
006 EMPLOYEE BENEFITS	750		5,636,000			
006 01 NONPATIENT TELEPHONES		2,500		116		
006 02 DATA PROCESSING					50	
006 03 PURCHASING, RECEIVING			35,000	5		421,720
006 04 ADMITTING	500	150	50,000			2,000
006 05 CASHIERING/ACCOUNTS R	2,000	12,000	200,000	10		11,000
006 06 OTHER ADMINISTRATIVE	3,500	65,000	330,000	20	25	20,000
007 MAINTENANCE & REPAIRS						
008 OPERATION OF PLANT	2,000	15,000	150,000	5		45,000
009 LAUNDRY & LINEN SERVI		250	25,000			3,000
010 HOUSEKEEPING	1,000	50	200,000			30,000
011 DIETARY	1,000	2,000	400,000	5		
012 CAFETERIA	3,000					
014 NURSING ADMINISTRATION	1,000	1,000	200,000	5	1	1,000
015 CENTRAL SERVICES & SU						
016 PHARMACY						
017 MEDICAL RECORDS & LIB	800	1,500	100,000	10	10	5,000
018 SOCIAL SERVICE	75		50,000	5	1	20
020 NONPHYSICIAN ANESTHET						
021 NURSING SCHOOL						
022 I&R SERVICES-SALARY &						
023 I&R SERVICES-OTHER PR						
024 PARAMED ED PRGM-(SPEC						
025 INPAT ROUTINE SRVC CN						
025 ADULTS & PEDIATRICS	5,000	12,000	600,000	5		60,000
033 NURSERY	1,200	4,000	105,000	1		25,000
035 NURSING FACILITY	10,000	5,000	700,000	5		50,000
035 01 ICF/MR						
039 ANCILLARY SRVC COST C						
041 DELIVERY ROOM & LABOR			280,000			
044 RADIOLOGY-DIAGNOSTIC	2,000	65,000	200,000	5	2	50,000
046 LABORATORY	700	5,000	200,000	5	2	
046 30 BLOOD CLOTTING FACTOR						
048 INTRAVENOUS THERAPY			10,000			2,000
050 PHYSICAL THERAPY	2,500	2,000		5	1	7,000
051 OCCUPATIONAL THERAPY						700
052 SPEECH PATHOLOGY						
053 ELECTROCARDIOLOGY	25					4,000
055 MEDICAL SUPPLIES CHAR	2,000		30,000			15,000
056 DRUGS CHARGED TO PATI	70		20,000			
059 MRI			1,000			
061 OUTPAT SERVICE COST C						
062 EMERGENCY	4,000	1,500	550,000	10	2	30,000
063 OBSERVATION BEDS (NON						
063 50 RURAL HEALTH CLINIC	7,000	3,000	870,000	10	5	55,000
063 60 FQHC						
069 OTHER REIMBURS COST C						
071 10 CMHC						
071 HOME HEALTH AGENCY						
085 SPEC PURPOSE COST CEN						
085 01 PANCREAS ACQUISITION						
085 02 INTESTINAL ACQUISITIO						
095 SUBTOTALS	50,120	196,950	5,306,000	111	49	415,720
100 NONREIMBURS COST CENT						
100 MEDICAL OFFICE BUILDI	15,000	5,000	300,000	5	1	6,000
100 01 GIFT SHOP						
100 02 PHYSICIAN OFFICES						
100 03 FOUNDATIONS			30,000			
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	A 295,000	236,000	1,253,398	32,922	30,000	73,203
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	4.530098		.222391		600.000000	
(WRKSHT B, PT I)						
105 COST TO BE ALLOCATED	A = Total Costs = \$295,000 = 4.53		1.168606	283.810345		.173582
(WRKSHT B, PART II)	B = Total Stats = 65,120		= approx. 1			
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED			3,398	2,922		147
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER			.000603	25.189655		.000349
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	RECONCILIATION	OTHER ADMINISTRATIVE AND	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
	(NUMBER OF MITS)	AD(GROSS REVENUE)	()	(ACCUM. COST	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)
	6.04	6.05	6a.06	6.06	7	8	9
GENERAL SERVICE COST							
003 NEW CAP REL COSTS-BLD							
004 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING, RECEIVING							
006 04 ADMINISTRATION	225						
006 05 CASHIERING/ACCOUNTS R		11,820,000					
006 06 OTHER ADMINISTRATIVE			-1,149,954	9,610,056			
007 MAINTENANCE & REPAIRS						56,370	
008 OPERATION OF PLANT				419,178			
009 LAUNDRY & LINEN SERVI				131,373			176,000
010 HOUSEKEEPING				284,273		1,000	15,000
011 DIETARY				732,242		1,000	2,000
012 CAFETERIA				13,590		3,000	
014 NURSING ADMINISTRATION				282,230		1,000	
015 CENTRAL SERVICES & SU							
016 PHARMACY							
017 MEDICAL RECORDS & LIB				187,072		800	
018 SOCIAL SERVICE				64,482		75	
020 NONPHYSICIAN ANESTHET							
021 NURSING SCHOOL							
022 I & R SERVICES-SALARY &							
023 I & R SERVICES-OTHER PR							
024 PARAMED ED PRGM-(SPEC							
INPAT ROUTINE SRVC CN							
025 ADULTS & PEDIATRICS	200	1,500,000		986,693		5,000	35,000
033 NURSERY		350,000		364,020		1,200	10,000
035 NURSING FACILITY	5	1,350,000		1,159,060		10,000	80,000
035 01 ICF/MR							
ANCILLARY SRVC COST C							
039 DELIVERY ROOM & LABOR		350,000		753,204			10,000
041 RADIOLOGY-DIAGNOSTIC		750,000		594,228		2,000	5,000
044 LABORATORY		1,250,000		565,166		700	
046 30 BLOOD CLOTTING FACTOR							
048 INTRAVENOUS THERAPY		200,000		25,820			
050 PHYSICAL THERAPY		500,000		332,518		2,500	5,500
051 OCCUPATIONAL THERAPY		200,000		106,371			
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY		70,000		12,994		25	
055 MEDICAL SUPPLIES CHAR		100,000		125,460		2,000	
056 DRUGS CHARGED TO PATI		400,000		137,263		70	
059 MRI		500,000		116,844			
OUTPAT SERVICE COST C							
061 EMERGENCY		2,000,000		743,926		4,000	5,000
062 OBSERVATION BEDS (NON							
063 RURAL HEALTH CLINIC		1,500,000		1,290,950		7,000	500
063 60 FQHC							
OTHER REIMBURS COST C							
069 10 CMHC							
071 HOME HEALTH AGENCY							
SPEC PURPOSE COST CEN							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITIO							
095 SUBTOTALS	205	11,020,000	-1,149,954	9,428,957		41,370	168,000
NONREIMBURS COST CENT							
100 MEDICAL OFFICE BUILDI	20	800,000		174,427		15,000	8,000
100 01 GIFT SHOP							
100 02 PHYSICIAN OFFICES							
100 03 FOUNDATIONS				6,672			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	65,907	369,308		1,149,954		469,338	147,093
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER		.031244		.119662		8.326024	.835756
(WRKSHT B, PT I)	292.920000						
105 COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
(WRKSHT B, PT II)	2,471	23,460		92,525		30,857	1,573
107 COST TO BE ALLOCATED							
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER	10.982222	.001985		.009628		.547401	.008938
(WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
	(HOURS OF SERVICE)	(MEALS SERVED)	(FTE'S X 100)	(DIRECT NRSNG HRS)	(SUPPLIES EXPENSE)	(SQUARE FEET)	(TIME SPENT)
GENERAL SERVICE COST	10	11	12	14	15	16	17
003 NEW CAP REL COSTS-BLD							
004 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING, RECEIVING							
006 04 ADMITTING							
006 05 CASHIERING/ACCOUNTS R							
006 06 OTHER ADMINISTRATIVE							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	18,500						
011 DIETARY	1,500	87,085					
012 CAFETERIA		20,000	10,365				
014 NURSING ADMINISTRATION			400	156,400			
015 CENTRAL SERVICES & SU							
016 PHARMACY							
017 MEDICAL RECORDS & LIB	300		500				5,075
018 SOCIAL SERVICE			100	2,000			
020 NONPHYSICIAN ANESTHET							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY &							
023 I&R SERVICES-OTHER PR							
024 PARAMED ED PRGM-(SPEC							
INPAT ROUTINE SRVC CN							
025 ADULTS & PEDIATRICS	5,000	12,000	2,000	40,000			500
033 NURSERY	1,250		500	10,000			50
035 NURSING FACILITY	5,000	30,000	2,000	40,000			50
035 01 ICF/MR							
ANCILLARY SRVC COST C							
039 DELIVERY ROOM & LABOR	1,000		500	10,000			75
041 RADIOLOGY-DIAGNOSTIC	500		1,000				300
044 LABORATORY	500		500				400
046 30 BLOOD CLOTTING FACTOR							
048 INTRAVENOUS THERAPY			15	400			
050 PHYSICAL THERAPY	200						100
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY			25				
055 MEDICAL SUPPLIES CHAR			100				
056 DRUGS CHARGED TO PATI			25				
059 MRI							
OUTPAT SERVICE COST C							
061 EMERGENCY	1,000	85	700	9,000			1,500
062 OBSERVATION BEDS (NON							
063 RURAL HEALTH CLINIC	250		1,000	25,000			2,000
063 60 FQHC							
OTHER REIMBURS COST C							
069 10 CMHC							
071 HOME HEALTH AGENCY							
SPEC PURPOSE COST CEN							
085 01 PANCREAS ACQUISITION							
085 02 INTESTINAL ACQUISITIO							
095 SUBTOTALS	16,500	62,085	9,365	136,400			4,975
NONREIMBURS COST CENT							
100 MEDICAL OFFICE BUILDI	2,000	25,000	1,000	20,000			100
100 01 GIFT SHOP							
100 02 PHYSICIAN OFFICES							
100 03 FOUNDATIONS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	339,152	857,361	237,096	333,478			233,055
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER		9.845105		2.132212			
(WRKSHT B, PT I)	18.332541		22.874674				45.922167
COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
(WRKSHT B, PT II)							
107 COST TO BE ALLOCATED	8,137	15,509	18,925	9,940			8,975
(WRKSHT B, PART III							
108 UNIT COST MULTIPLIER		.178090		.063555			
(WRKSHT B, PT III)	.439838		1.825856				1.768473

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	SOCIAL SERVICE (LONG TERM CARE DAYS)	NONPHYSICIAN ANESTHETISTS (100% TO LINE 40)	NURSING SCHOOL (SQUARE FEET)	I&R SERVICES-SALARY & FRI (TIME SPENT)	I&R SERVICES-OTHER PRGM C (SQUARE FEET)	PARAMED ED PRGM-(SPECIFY) (SQUARE FEET)
	18	20	21	22	23	24
GENERAL SERVICE COST						
003 NEW CAP REL COSTS-BLD						
004 NEW CAP REL COSTS-MVB						
005 EMPLOYEE BENEFITS						
006 01 NONPATIENT TELEPHONES						
006 02 DATA PROCESSING						
006 03 PURCHASING, RECEIVING						
006 04 ADMITTING						
006 05 CASHIERING/ACCOUNTS R						
006 06 OTHER ADMINISTRATIVE						
007 MAINTENANCE & REPAIRS						
008 OPERATION OF PLANT						
009 LAUNDRY & LINEN SERVICE						
010 HOUSEKEEPING						
011 DIETARY						
012 CAFETERIA						
014 NURSING ADMINISTRATION						
015 CENTRAL SERVICES & SUPPLY						
016 PHARMACY						
017 MEDICAL RECORDS & LIBRARY						
018 SOCIAL SERVICE	14,000					
020 NONPHYSICIAN ANESTHETIST						
021 NURSING SCHOOL						
022 I&R SERVICES-SALARY & FRI						
023 I&R SERVICES-OTHER PRGM C						
024 PARAMED ED PRGM-(SPECIFY)						
025 ADULTS & PEDIATRICS	4,000					
033 NURSERY						
035 NURSING FACILITY	10,000					
035 01 ICF/MR						
039 ANCILLARY SRVC COST CENTER						
041 DELIVERY ROOM & LABORATORY						
044 RADIOLOGY-DIAGNOSTIC LABORATORY						
046 30 BLOOD CLOTTING FACTOR						
048 INTRAVENOUS THERAPY						
050 PHYSICAL THERAPY						
051 OCCUPATIONAL THERAPY						
052 SPEECH PATHOLOGY						
053 ELECTROCARDIOLOGY						
055 MEDICAL SUPPLIES CHARACTER						
056 DRUGS CHARGED TO PATIENT						
059 MRI						
061 OUTPAT SERVICE COST CENTER						
062 EMERGENCY						
063 OBSERVATION BEDS (NON-RURAL HEALTH CLINIC)						
063 50 FQHC						
063 60 OTHER REIMBURS COST CENTER						
069 10 CMHC						
071 HOME HEALTH AGENCY SPEC PURPOSE COST CENTER						
085 01 PANCREAS ACQUISITION						
085 02 INTESTINAL ACQUISITION						
095 SUBTOTALS	14,000					
100 NONREIMBURS COST CENTER						
100 MEDICAL OFFICE BUILDING						
100 01 GIFT SHOP						
100 02 PHYSICIAN OFFICES						
100 03 FOUNDATIONS						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED (PER WRKSHT B, PART I)	79,373					
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)	5.669500					
105 COST TO BE ALLOCATED (PER WRKSHT B, PART I)						
106 UNIT COST MULTIPLIER (WRKSHT B, PT I)						
107 COST TO BE ALLOCATED (PER WRKSHT B, PART I)	1,468					
108 UNIT COST MULTIPLIER (WRKSHT B, PT I)	.104857					

PROVIDER NO: 50-1300 PERIOD: FROM 1/1/2008 TO 12/31/2008 PREPARED 10/10/2009 WORKSHEET C PART I

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
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	1,562,126		1,562,126		
33	NURSERY	483,899		483,899		
35	NURSING FACILITY	2,024,918		2,024,918		
35	01 ICF/MR					
	ANCILLARY SRVC COST CNTRS					
39	DELIVERY ROOM & LABOR ROO	906,228		906,228		
41	RADIOLOGY-DIAGNOSTIC	731,984		731,984		
44	LABORATORY	677,595		677,595		
46	30 BLOOD CLOTTING FACTORS AD					
48	INTRAVENOUS THERAPY	30,106		30,106		
50	PHYSICAL THERAPY	405,979		405,979		
51	OCCUPATIONAL THERAPY	119,100		119,100		
52	SPEECH PATHOLOGY					
53	ELECTROCARDIOLOGY	15,329		15,329		
55	MEDICAL SUPPLIES CHARGED	159,412		159,412		
56	DRUGS CHARGED TO PATIENTS	154,843		154,843		
59	MRI	130,826		130,826		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	993,684		993,684		
62	OBSERVATION BEDS (NON-DIS	17,266	from D-1, Part III	17,266		
63	50 RURAL HEALTH CLINIC	1,676,730		1,676,730		
63	60 FQHC					
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	10,090,025		10,090,025		
102	LESS OBSERVATION BEDS	17,266		17,266		
103	TOTAL	10,072,759	from WS B, Part I, Column 27	10,072,759		

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
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,200,000		1,200,000			
33	NURSERY	500,000		500,000			
35	NURSING FACILITY	2,000,000		2,000,000			
35	01 ICF/MR						
	ANCILLARY SRVC COST CNTRS						
39	DELIVERY ROOM & LABOR ROO	500,000	500,000	1,000,000	.906228	.906228	
41	RADIOLOGY-DIAGNOSTIC	60,000	1,500,000	1,560,000	.469221	.469221	
44	LABORATORY	150,000	1,500,000	1,650,000	.410664	.410664	
46	30 BLOOD CLOTTING FACTORS AD						
48	INTRAVENOUS THERAPY	8,000	150,000	158,000	.190544	.190544	
50	PHYSICAL THERAPY	100,000	400,000	500,000	.811958	.811958	
51	OCCUPATIONAL THERAPY	80,000	150,000	230,000	.517826	.517826	
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY	5,000	65,000	70,000	.218986	.218986	
55	MEDICAL SUPPLIES CHARGED	25,000	85,000	110,000	1.449200	1.449200	
56	DRUGS CHARGED TO PATIENTS	200,000	250,000	450,000	.344096	.344096	
59	MRI	10,000	500,000	510,000	.256522	.256522	
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	50,000	1,500,000	1,550,000	.641086	.641086	
62	OBSERVATION BEDS (NON-DIS		90,000	90,000	.191844	.191844	
63	50 RURAL HEALTH CLINIC		2,000,000	2,000,000	.838365	.838365	
63	60 FQHC						
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	4,888,000	8,690,000	13,578,000			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,888,000	8,690,000	13,578,000			

Fully loaded costs = \$731,984
Total Charges = \$1,560,000

Column 1 = \$677,595
Column 8 = \$1,650,000

IP and OP Charges from
Revenue by Revenue Code and
other internal reports

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
39	ANCILLARY SRVC COST CNTRS	906,228	10,327	895,901			906,228
41	DELIVERY ROOM & LABOR ROO	731,984	96,210	635,774			731,984
44	LABORATORY	677,595	19,406	658,189			677,595
46	30 BLOOD CLOTTING FACTORS AD						
48	INTRAVENOUS THERAPY	30,106	705	29,401			30,106
50	PHYSICAL THERAPY	405,979	19,667	386,312			405,979
51	OCCUPATIONAL THERAPY	119,100	1,421	117,679			119,100
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY	15,329	438	14,891			15,329
55	MEDICAL SUPPLIES CHARGED	159,412	11,768	147,644			159,412
56	DRUGS CHARGED TO PATIENTS	154,843	2,529	152,314			154,843
59	MRI	130,826	2,119	128,707			130,826
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	993,684	38,787	954,897			993,684
62	OBSERVATION BEDS (NON-DIS	17,266		17,266			17,266
63	50 RURAL HEALTH CLINIC	1,676,730	62,316	1,614,414			1,676,730
63	60 FQHC						
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	6,019,082	265,693	5,753,389			6,019,082
102	LESS OBSERVATION BEDS	17,266		17,266			17,266
103	TOTAL	6,001,816	265,693	5,736,123			6,001,816

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
39	DELIVERY ROOM & LABOR ROO	1,000,000	.906228	.906228
41	RADIOLOGY-DIAGNOSTIC	1,560,000	.469221	.469221
44	LABORATORY	1,650,000	.410664	.410664
46	30 BLOOD CLOTTING FACTORS AD			
48	INTRAVENOUS THERAPY	158,000	.190544	.190544
50	PHYSICAL THERAPY	500,000	.811958	.811958
51	OCCUPATIONAL THERAPY	230,000	.517826	.517826
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	70,000	.218986	.218986
55	MEDICAL SUPPLIES CHARGED	110,000	1.449200	1.449200
56	DRUGS CHARGED TO PATIENTS	450,000	.344096	.344096
59	MRI	510,000	.256522	.256522
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	1,550,000	.641086	.641086
62	OBSERVATION BEDS (NON-DIS	90,000	.191844	.191844
63	50 RURAL HEALTH CLINIC	2,000,000	.838365	.838365
63	60 FQHC			
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	9,878,000		
102	LESS OBSERVATION BEDS	90,000		
103	TOTAL	9,788,000		

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
39	ANCILLARY SRVC COST CNTRS					
	DELIVERY ROOM & LABOR ROO	41,928				
41	RADIOLOGY-DIAGNOSTIC	777,597	1,560,000			
44	LABORATORY	713,563	1,650,000			
46	30 BLOOD CLOTTING FACTORS AD					
48	INTRAVENOUS THERAPY	30,309	158,000			
50	PHYSICAL THERAPY	410,710	500,000			
51	OCCUPATIONAL THERAPY	119,653	230,000			
52	SPEECH PATHOLOGY					
53	ELECTROCARDIOLOGY	15,470	70,000			
55	MEDICAL SUPPLIES CHARGED	162,388	110,000			
56	DRUGS CHARGED TO PATIENTS	155,709	450,000			
59	MRI	130,798	510,000			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,021,983	1,550,000			
62	OBSERVATION BEDS (NON-DIS	31,212	90,000			
63	50 RURAL HEALTH CLINIC	1,740,849	2,000,000			
63	60 FQHC					
	OTHER REIMBURS COST CNTRS					
101	TOTAL	5,352,169	8,878,000			

COMPUTATION OF OUTPATIENT COST PER VISIT -
 RURAL PRIMARY CARE HOSPITAL

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 ANCI LLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
39	ANCI LLARY SRVC COST CNTRS	41,928		41,928				
41	DELI VERY ROOM & LABOR ROO	777,597	100,000	877,597	1,560,000			
44	LABORATORY	713,563		713,563	1,650,000			
46	30 BLOOD CLOTTI NG FACTORS AD							
48	INTRA VENOUS THERAPY	30,309		30,309	158,000			
50	PHYSI CAL THERAPY	410,710		410,710	500,000			
51	OCCUPATI ONAL THERAPY	119,653		119,653	230,000			
52	SPEECH PATHOLOGY							
53	ELECTROCARDIOLOGY	15,470		15,470	70,000			
55	MEDI CAL SUPPLI ES CHARGED	162,388		162,388	110,000			
56	DRUGS CHARGED TO PATIENTS	155,709		155,709	450,000			
59	MRI	130,798		130,798	510,000			
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY	1,021,983	100,000	1,121,983	1,550,000			
62	OBSERVATI ON BEDS (NON-DIS	31,212		31,212	90,000			
63	50 RURAL HEALTH CLINI C							
63	60 FQHC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	3,611,320	200,000	3,811,320	6,878,000			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TIT LE V OUTPATI ENT VISITS							
105	TIT LE XVII I OUTPAT VISITS							
106	TIT LE XI X OUTPAT VISITS							
107	TIT LE V OUTPAT COSTS							
108	TIT LE XVII I OUTPAT COSTS							
109	TIT LE XI X OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED
50-1300	FROM 1/ 1/2008	10/10/2009
COMPONENT NO:	TO 12/31/2008	WORKSHEET D
50-1300		PART V

TITLE XVIII, PART B

HOSPITAL

Payor - Title XVIII - Medicare
Title XIX - Medicaid

	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
Cost Center Description	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
39 DELIVERY ROOM & LABOR ROOM	.906228		.906228		
41 RADIOLOGY-DIAGNOSTIC	.469221		.469221		
44 LABORATORY	.410664		.410664		
46 30 BLOOD CLOTTING FACTORS ADMIN COSTS					
48 INTRAVENOUS THERAPY	.190544		.190544		
50 PHYSICAL THERAPY	.811958		.811958		
51 OCCUPATIONAL THERAPY	.517826		.517826		
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY	.218986		.218986		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.449200		1.449200		
56 DRUGS CHARGED TO PATIENTS	.344096		.344096		
59 MRI	.256522		.256522		
61 OUTPAT SERVICE COST CNTRS					
EMERGENCY	.641086		.641086		
62 OBSERVATION BEDS (NON-DISTINCT PART)	.191844		.191844		
63 50 RURAL HEALTH CLINIC					
60 FOHC					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 10/10/2009
I	50-1300	I	FROM 1/ 1/2008	I	WORKSHEET D
I	COMPONENT NO:	I	TO 12/31/2008	I	PART VI
I	50-1300	I		I	

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

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

1	.344096	
	1,167	Vaccine charges
	402	Vaccine costs

PROVIDER NO:	PERIOD:	PREPARED 10/10/2009
50-1300	FROM 1/ 1/2008	WORKSHEET D-1 PART I
COMPONENT NO:	TO 12/31/2008	
50-1300		

COMPUTATION OF INPATIENT OPERATING COST

TITLE XVIII PART A

HOSPITAL

OTHER

Medicare, Inpatient

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	[A]	5,650	from WS S-3
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)		2,050	Acute + Obs from WS S-3
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)			
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		2,050	
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		1,600	SNF Swing Days
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)			
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	[B]	2,000	NF Swing Days
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)			
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)		1,200	Medicare Acute Days
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		1,500	
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)	[A] - [B]	= 3,650 Days	[C]
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		150.87	Medicaid Rate
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		150.87	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST			
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		1,562,126	from WS B, Part I, Column 27
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		301,740	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD			
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		854,236	total Swing bed costs
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST		707,890	

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT **Cost per day without NF carveout is less; NF carveout is beneficial

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	351,600
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	351,600
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.013339
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	171.51
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	707,890

[D] - [E] = \$1,260,386 [F]
Costs used to calculate cost per day

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					345.31 = F / C
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					414,372
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					414,372
		TOTAL	TOTAL	AVERAGE	PROGRAM	PROGRAM
		I/P COST	I/P DAYS	PER DIEM	DAYS	COST
		1	2	3	4	5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT					
	HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	from WS B, Part I	from WS S-3	Calculated	from WS S-3	Calculated
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					142,186 Ancillary costs
49	TOTAL PROGRAM INPATIENT COSTS					556,558 Total Inpatient costs

Routine costs
 = 1,200 Medicare days x \$345.31

**Interim rates for ICU and other hospital units are
 the same as Acute care, but separate rate calculated
 and settled through the Medicare cost report

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)	517,965
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	517,965
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	

PROVIDER NO:	PERIOD:	PREPARED 10/10/2009
50-1300	FROM 1/ 1/2008	WORKSHEET D-1
COMPONENT NO:	TO 12/31/2008	PART III
50-1300		

COMPUTATION OF INPATIENT OPERATING COST

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	50
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	345.31
85	OBSERVATION BED COST	17,266 to WSC, Part I

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 COMPONENT NO: 50-1300
 PREPARED 10/10/2009
 WORKSHEET D-4

TITLE XVIII, PART A

HOSPITAL

OTHER
 from WS C from PS&R Calculated

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		247,797	
39	ANCILLARY SRVC COST CNTRS DELIVERY ROOM & LABOR ROOM	.906228	61,840	56,041
41	RADIOLOGY-DIAGNOSTIC	.469221	18,148	8,515
44	LABORATORY	.410664	68,502	28,131
46	30 BLOOD CLOTTING FACTORS ADMIN COSTS			
48	INTRAVENOUS THERAPY	.190544	277	53
50	PHYSICAL THERAPY	.811958	3,607	2,929
51	OCCUPATIONAL THERAPY	.517826	981	508
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	.218986	2,094	459
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.449200	11,931	17,290
56	DRUGS CHARGED TO PATIENTS	.344096	73,909	25,432
59	MRI	.256522		
61	OUTPAT SERVICE COST CNTRS EMERGENCY	.641086	4,411	2,828
62	OBSERVATION BEDS (NON-DISTINCT PART)	.191844		
63	50 RURAL HEALTH CLINIC			
63	60 FOHC			
101	OTHER REIMBURS COST CNTRS TOTAL		245,700	142,186
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			Routine and ancillary costs for Inpatient;
103	NET CHARGES		245,700	Feeds back to WS D-1

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO:	PERIOD:	PREPARED 10/10/2009
50-1300	FROM 1/ 1/2008	WORKSHEET D-4
COMPONENT NO:	TO 12/31/2008	
50-2000		

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			
39	ANCILLARY SRVC COST CNTRS			
41	DELIVERY ROOM & LABOR ROOM	. 906228		
44	RADIOLOGY-DIAGNOSTIC	. 469221	16,984	7,969
46	LABORATORY	. 410664	23,937	9,830
48	30 BLOOD CLOTTING FACTORS ADMIN COSTS			
50	INTRAVENOUS THERAPY	. 190544		
51	PHYSICAL THERAPY	. 811958	90,222	73,256
52	OCCUPATIONAL THERAPY	. 517826	64,219	33,254
53	SPEECH PATHOLOGY			
55	ELECTROCARDIOLOGY	. 218986	236	52
56	MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 449200	4,877	7,068
59	DRUGS CHARGED TO PATIENTS	. 344096	43,564	14,990
61	MRI	. 256522	4,610	1,183
62	OUTPAT SERVICE COST CNTRS			
63	EMERGENCY	. 641086		
63	50 OBSERVATION BEDS (NON-DISTINCT PART)	. 191844		
63	60 RURAL HEALTH CLINIC			
63	60 FOHC			
101	OTHER REIMBURS COST CNTRS			
102	TOTAL		248,649	147,602
103	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			x 101% = \$149,078
103	NET CHARGES		248,649	to WS E-2 (Swing)

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO: 50-1300
 COMPONENT NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	906,314	from WS D, part V, Line 104, Column 4 + WS D, part VI, Line 3 (vaccines)
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).		
<hr/>			
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.		TOPS payments for PPS Hospitals (N/A for CAHs)
1.05	LINE 1.02 DIVIDED BY LINE 1.04.		
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.		
2	INTERNS AND RESIDENTS		
3	ORGAN ACQUISITIONS		
4	COST OF TEACHING PHYSICIANS		
5	TOTAL COST (SEE INSTRUCTIONS)	906,314	subtotal
	COMPUTATION OF LESSER OF COST OR CHARGES		\$906,314 x 101% = \$915,377
	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)	915,377	
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)		
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	10,771	
18.01	CAH ACTUAL BILLED COINSURANCE	258,544	
	LINE 17.01 (SEE INSTRUCTIONS)		
19	SUBTOTAL (SEE INSTRUCTIONS)	646,062	
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	646,062	
24	PRIMARY PAYER PAYMENTS	670	primary payor payments (if any)
25	SUBTOTAL	645,392	subtotal
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD		
27	BAD DEBTS (SEE INSTRUCTIONS)	10,467	
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	10,467	All bad debts
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		Medicaid crossovers only
28	SUBTOTAL	655,859	**Bad Debts Allowed: 100% for CAH 70% for PPS Hospitals
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	655,859	
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
34	INTERIM PAYMENTS	506,697	
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
35	BALANCE DUE PROVIDER/PROGRAM	149,162	Net settlement amount, to WS E-1 Settlement to WS S
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2		
	TO BE COMPLETED BY CONTRACTOR		
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)		
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		
54	TOTAL (SUM OF LINES 51 AND 53)		

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO: 50-1300
 COMPONENT NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET E-1

TITLE XVII HOSPITAL

DESCRIPTION

Part A - Inpatient		Part B - Outpatient	
MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1	2	3	4
	170,114		857,167
	NONE		NONE

Net Reimbursement from PS&R

- TOTAL INTERIM PAYMENTS PAID TO PROVIDER
- 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.
- 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)

Lump Sum Adjustments

ADJUSTMENTS TO PROVIDER	.01	10/30/2007	74,100	
ADJUSTMENTS TO PROVIDER	.02			
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
<hr/>				
ADJUSTMENTS TO PROGRAM	.50	10/30/2007		350,470
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
ADJUSTMENTS TO PROGRAM	.99		74,100	-350,470
SUBTOTAL			244,214	506,697

- TOTAL INTERIM PAYMENTS

- TO BE COMPLETED BY INTERMEDIARY
- LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)

****Settlement Calculations:**
 PPS Hospitals - WS E, Part A
 CAH Hospitals - WS E-3, Part II
 Swing Bed SNF - WS E-2

Total interim payments, to WS E, Part B

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
DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	.01		258,097	149,162
SETTLEMENT TO PROVIDER	.02			
7 TOTAL MEDICARE PROGRAM LIABILITY			502,311	655,859

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.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO: 50-1300
 COMPONENT NO: 50-2000
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET E-1

TITLE XVII I

SWING BED SNF

DESCRIPTION	INPATIENT-PART A		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,028,992		
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	Net Reimbursement from PS&R	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)		Lump Sum Adjustments		
ADJUSTMENTS TO PROVIDER	.01	10/30/2007	267,600	
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			
ADJUSTMENTS TO PROGRAM	.99			
SUBTOTAL			267,600	NONE
4 TOTAL INTERIM PAYMENTS			1,296,592	
TO BE COMPLETED BY INTERMEDIARY			Total interim payments to WS E-2	
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			
TENTATIVE TO PROGRAM	.99			
SUBTOTAL			NONE	NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			720,461	
7 TOTAL MEDICARE PROGRAM LIABILITY			576,131	

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.

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

PROVIDER NO:	PERIOD:	PREPARED 10/10/2009
50-1300	FROM 1/ 1/2008	
COMPONENT NO:	TO 12/31/2008	WORKSHEET E-2
50-Z000		

TITLE XVII I SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	523,145	Includes additional 1%
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	149,078	from WS D-4 x 101%
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	1,500	Processed Medicare Swing bed days
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	672,223	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	672,223	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	672,223	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	96,720	
14	80% OF PART B COSTS		
15	SUBTOTAL	575,503	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS	628	
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	628	
18	TOTAL	576,131	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,296,592	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-720,461	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)	5,600	

Interim rates for Swing Bed = $(\$523,145 + \$149,078) / 1,500 \text{ days}$
= \$448.15 / day

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

PROVIDER NO:	PERIOD:	PREPARED 10/10/2009
50-1300	FROM 1/ 1/2008	
COMPONENT NO:	TO 12/31/2008	WORKSHEET E-2
50-0000		

TITLE XIX SWING BED NF

COMPUTATION OF NET COST OF COVERED SERVICES

PART A
1

PART B
2

1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)	
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)	
5	PROGRAM DAYS	1,500
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)	
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY	
8	SUBTOTAL	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	
10	SUBTOTAL	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)	
12	SUBTOTAL	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	
14	80% OF PART B COSTS	
15	SUBTOTAL	
16	OTHER ADJUSTMENTS (SPECIFY)	
17	REIMBURSABLE BAD DEBTS	
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
18	TOTAL	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
20	INTERIM PAYMENTS	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
21	BALANCE DUE PROVIDER/PROGRAM	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2.	

I PROVIDER NO:	I PERIOD:	I PREPARED 10/10/2009
I 50-1300	I FROM 1/ 1/2008	I WORKSHEET E-3
I COMPONENT NO:	I TO 12/31/2008	I PART II
I 50-1300	I	I

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	556,558	from WS D-1
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		
2	ORGAN ACQUISITION		
3	COST OF TEACHING PHYSICIANS		
4	SUBTOTAL	556,558	
5	PRIMARY PAYER PAYMENTS		
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	562,124	= \$556,558 x 101%

COMPUTATION OF LESSER OF COST OR CHARGES

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

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		
19	COST OF COVERED SERVICES	562,124	
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	63,488	Inpatient Deductibles
21	EXCESS REASONABLE COST		
22	SUBTOTAL	498,636	
23	COINSURANCE	49	
24	SUBTOTAL	498,587	
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	3,724	Medicare bad debts,
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	3,724	including Medicaid Crossovers
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		**Bad Debts Allowed:
26	SUBTOTAL	502,311	100% for CAH
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		70% for PPS Hospitals
28	OTHER ADJUSTMENTS (SPECIFY)		
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
30	SUBTOTAL	502,311	
31	SEQUESTRATION ADJUSTMENT		
32	INTERIM PAYMENTS	244,214	
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
33	BALANCE DUE PROVIDER/PROGRAM	258,097	
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2.	21,940	

BALANCE SHEET

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
ASSETS				
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	300,000			
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	2,000,000			
5 OTHER RECEIVABLES	150,000			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-650,000			
7 INVENTORY	50,000			
8 PREPAID EXPENSES	90,000			
9 OTHER CURRENT ASSETS	20,000			
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS	1,960,000			
FIXED ASSETS				
12 LAND	50,000			
12.01 LAND IMPROVEMENTS	50,000			
13.01 LESS ACCUMULATED DEPRECIATION	-60,000			
14 BUILDINGS	9,000,000			
14.01 LESS ACCUMULATED DEPRECIATION	-2,500,000			
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT	1,000,000			
16.01 LESS ACCUMULATED DEPRECIATION	-500,000			
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT	2,000,000			
18.01 LESS ACCUMULATED DEPRECIATION	-2,500,000			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	6,540,000			
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS	2,954,000			
26 TOTAL OTHER ASSETS	2,954,000			
27 TOTAL ASSETS	11,454,000			

BALANCE SHEET

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE			
	429,400			
29	SALARIES, WAGES & FEES PAYABLE			
	450,000			
30	PAYROLL TAXES PAYABLE			
31	NOTES AND LOANS PAYABLE (SHORT TERM)			
	350,000			
32	DEFERRED INCOME			
33	ACCELERATED PAYMENTS			
34	DUE TO OTHER FUNDS			
35	OTHER CURRENT LIABILITIES			
	500,000			
36	TOTAL CURRENT LIABILITIES			
	1,729,400			
LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE			
38	NOTES PAYABLE			
	4,000,000			
39	UNSECURED LOANS			
40.01	LOANS PRIOR TO 7/1/66			
40.02	ON OR AFTER 7/1/66			
41	OTHER LONG TERM LIABILITIES			
42	TOTAL LONG-TERM LIABILITIES			
	4,000,000			
43	TOTAL LIABILITIES			
	5,729,400			
CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE			
	5,724,600			
45	SPECIFIC PURPOSE FUND			
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED			
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICTED			
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			
	5,724,600			
52	TOTAL LIABILITIES AND FUND BALANCES			
	11,454,000			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		5,090,000		
2 NET INCOME (LOSS)		484,600		
3 TOTAL		5,574,600		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6 PY AJE FOR COST REPORT SE	150,000			
7				
8				
9				
10 TOTAL ADDITIONS		150,000		
11 SUBTOTAL		5,724,600		
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		5,724,600		

should agree to prior year MCR, WS G, Line 19

agrees to WS G, Line 51

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	351,600		351,600
4 00 SWING BED - SNF	400,000		400,000
5 00 SWING BED - NF	500,000		500,000
7 00 NURSING FACILITY	2,000,000		2,000,000
7 01 ICF/MR			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	3,251,600		3,251,600
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,251,600		3,251,600
17 00 ANCILLARY SERVICES	600,000	4,500,000	5,100,000
18 00 OUTPATIENT SERVICES	50,000	1,500,000	1,550,000
18 50 RURAL HEALTH CLINIC		2,000,000	2,000,000
18 60 FQHC			
19 00 HOME HEALTH AGENCY			
21 10 CMHC			
24 00 ASSISTED LIVING	800,000		800,000
24 01 HOSPITAL BASED PHYSICIANS	20,000	1,000,000	1,020,000
25 00 TOTAL PATIENT REVENUES	4,721,600	9,000,000	13,721,600

should agree to gross patient revenues reported on financial statements

PART II - OPERATING EXPENSES

26 00 OPERATING EXPENSES	11,432,000		
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES	11,432,000		

agrees to WS A, Column 3, Line 101

STATEMENT OF REVENUES AND EXPENSES

PROVIDER NO: 50-1300
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES	13,721,600	from WS G, Part I
2	LESS: ALLOWANCES AND DISCOUNTS ON	3,000,000	
3	NET PATIENT REVENUES	10,721,600	
4	LESS: TOTAL OPERATING EXPENSES	11,432,000	from WS G, Part II
5	NET INCOME FROM SERVICE TO PATIENT OTHER INCOME	-710,400	
6	CONTRIBUTIONS, DONATIONS, BEQUES	150,000	
7	INCOME FROM INVESTMENTS	200,000	
8	REVENUE FROM TELEPHONE AND TELEG		
9	REVENUE FROM TELEVISION AND RADI		
10	PURCHASE DISCOUNTS		
11	REBATES AND REFUNDS OF EXPENSES		
12	PARKING LOT RECEIPTS		
13	REVENUE FROM LAUNDRY AND LINEN S		
14	REVENUE FROM MEALS SOLD TO EMPLO	60,000	
15	REVENUE FROM RENTAL OF LIVING QU		
16	REVENUE FROM SALE OF MEDICAL & S TO OTHER THAN PATIENTS	5,000	
17	REVENUE FROM SALE OF DRUGS TO OT		
18	REVENUE FROM SALE OF MEDICAL REC		
19	TUITION (FEES, SALE OF TEXTBOOKS		
20	REVENUE FROM GIFTS, FLOWER, COFFE		
21	RENTAL OF VENDING MACHINES		
22	RENTAL OF HOSPITAL SPACE		
23	GOVERNMENTAL APPROPRIATIONS		
24	OTHER OPERATING REVENUE (PHYSICIAN		
24.01	GRANTS	30,000	
24.02	LAB OTHER REVENUE	25,000	
24.03	RADIOLOGY COPY REVENUE		
24.04	ADMIN OTHER REVENUE	20,000	
24.05	FINANCE CHARGES	50,000	
24.07	TAX REVENUE	650,000	
24.08	SNF ACTIVITY REV	5,000	
25	TOTAL OTHER INCOME	1,195,000	
26	TOTAL	484,600	
	OTHER EXPENSES		
27	LOSS ON SALE OF SURPLUS		
28			
29			
30	TOTAL OTHER EXPENSES		
31	NET INCOME (OR LOSS) FOR THE PERIO	484,600	to WS G-1, Line 2

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

PROVIDER NO: 50-1300
COMPONENT NO: 50-0000
PERIOD: FROM 1/1/2008 TO 12/31/2008
PREPARED 10/10/2009
WORKSHEET M-1
Corresponds to WS A

RHC 1 Each RHC has its own set of M-series worksheets

A-6's for RHC I
RECLASSIFICATION

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATION 4
<u>FACILITY HEALTH CARE STAFF COSTS</u>				
1	PHYSICIAN	500,000	500,000	
2	PHYSICIAN ASSISTANT	5,000	5,000	
3	NURSE PRACTITIONER	145,000	145,000	-30,000
4	VISITING NURSE			
5	OTHER NURSE	150,000	150,000	
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	800,000	800,000	-30,000
<u>COSTS UNDER AGREEMENT</u>				
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
<u>OTHER HEALTH CARE COSTS</u>				
15	MEDICAL SUPPLIES			
16	TRANSPORTATION (HEALTH CARE STAFF)		60,000	
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)		60,000	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	800,000	60,000	860,000
		60,000		-30,000
<u>COSTS OTHER THAN RHC/FQHC SERVICES</u>				
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
<u>FACILITY OVERHEAD</u>				
29	FACILITY COSTS		10,000	
30	ADMINISTRATIVE COSTS	100,000	80,000	180,000
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	100,000	90,000	190,000
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	900,000	150,000	1,050,000
				-30,000

As a provider based RHC, should not have any expenses here

Agrees to WS A, Column 3, Line 63.5

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

PROVIDER NO: 50-1300
 COMPONENT NO: 50-0000
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET M-1

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	A-8's for RHC I ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	500,000	480,000
2	PHYSICIAN ASSISTANT	5,000	5,000
3	NURSE PRACTITIONER	115,000	115,000
4	VISITING NURSE		
5	OTHER NURSE	150,000	150,000
6	CLINICAL PSYCHOLOGIST		
7	CLINICAL SOCIAL WORKER		
8	LABORATORY TECHNICIAN		
9	OTHER FACILITY HEALTH CARE STAFF COSTS		
10	SUBTOTAL (SUM OF LINES 1-9)	770,000	750,000
COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT		
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		
13	OTHER COSTS UNDER AGREEMENT		
14	SUBTOTAL (SUM OF LINES 11-13)		
OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	60,000	60,000
16	TRANSPORTATION (HEALTH CARE STAFF)		
17	DEPRECIATION-MEDICAL EQUIPMENT		
18	PROFESSIONAL LIABILITY INSURANCE		
19	OTHER HEALTH CARE COSTS		
20	ALLOWABLE GME COSTS		
21	SUBTOTAL (SUM OF LINES 15-20)	60,000	60,000
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	830,000	810,000
COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY		
24	DENTAL		
25	OPTOMETRY		
26	ALL OTHER NONREIMBURSABLE COSTS		
27	NONALLOWABLE GME COSTS		
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		
FACILITY OVERHEAD			
29	FACILITY COSTS	10,000	10,000
30	ADMINISTRATIVE COSTS	180,000	180,000
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	190,000	190,000
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,020,000	1,000,000

Agrees to WS A,
Column 7, Line 63.5

ALLOCATION OF OVERHEAD
TO RHC/FOHC SERVICES

PROVIDER NO: 50-1300
 COMPONENT NO: 50-0000
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET M-2

VISITS AND PRODUCTIVITY		RHC 1	Actual visits from internal records	PRODUCTIVITY STANDARD(1)	FTEs x Productivity Standard
Based on actual hours worked + PTO (cannot exceed 1.0 FTE for each provider) Lower is better		NUMBER OF FTE PERSONNEL	TOTAL VISITS		MINIMUM VISITS
		1	2	3	4
POSITIONS					
1	PHYSICIANS	2.00	8,000	4,200	8,400
2	PHYSICIAN ASSISTANTS	.50	500	2,100	1,050
3	NURSE PRACTITIONERS	1.50	3,500	2,100	3,150
4	SUBTOTAL (SUM OF LINES 1-3)	4.00	12,000		12,600
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4.00	12,000		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FOHC SERVICES					
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	810,000			
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)	810,000			
13	RATIO OF RHC/FOHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000			
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	190,000			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	676,730			
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	866,730			
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	866,730			
19	OVERHEAD APPLICABLE TO RHC/FOHC SERVICES (LINE 13 X LINE 18)	866,730			
20	TOTAL ALLOWABLE COST OF RHC/FOHC SERVICES (SUM OF LINES 10 AND 19)	1,676,730			

\$1,000,000
 Agrees to M-1 and
 WS A, Column 7, Line 63.5

Hospital overhead from WS B, Part 1

Agrees to WS B, Part 1, Column 27, Line 63.5

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED 10/10/2009
50-1300	FROM 1/ 1/2008	WORKSHEET M-2
COMPONENT NO:	TO 12/31/2008	
50-0000		

RHC 1

VISITS AND PRODUCTIVITY

GREATER OF
COL. 2 OR
COL. 4
5

POSITIONS		
1 PHYSICIANS		
2 PHYSICIAN ASSISTANTS		
3 NURSE PRACTITIONERS		
4 SUBTOTAL (SUM OF LINES 1-3)	12,600	Greater of Column 2 (total visits) or Column 4 (min. visits). Considered in the aggregate (rather than by provider type).
5 VISITING NURSE		
6 CLINICAL PSYCHOLOGIST		
7 CLINICAL SOCIAL WORKER		
8 TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	12,600	
9 PHYSICIAN SERVICES UNDER AGREEMENTS		

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
 FOR RHC/FQHC SERVICES

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES		
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	1,676,730	
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	10,609	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,666,121	
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	12,600	Visits from WS M-2
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)		
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	12,600	
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	132.23	Rate per RHC I visit used in calculating settlement

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	
	1	2	
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	75.00	Does not apply for CAHs (or for RHC's attached to hospitals with less than 50 beds)
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	132.23	132.23
10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		4,000 from PS&R
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		528,920
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)*		528,920
16.01	PRIMARY PAYER AMOUNT		1,000
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		50,000 from PS&R
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		477,920
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		382,336 Net program costs, less 20% coinsurance
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		4,964 from WS M-4
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		387,300
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		4,000
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)		391,300
25	INTERIM PAYMENTS		401,500 from WS M-5
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		-10,200 to WS S (settlement)
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, CHAPTER I, SECTION 115.2		Protested amounts?

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

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

PROVIDER NO: 50-1300
 COMPONENT NO: 50-0000
 PERIOD: FROM 1/ 1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET M-4

TITLE XVII I RHC 1

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	750,000	750,000	
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000100	.001000	(time per injection x # of injections) total RHC staff time
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	75	750	
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	2,000	2,300	Includes costs of all supplies, including unused vaccines
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	2,075	3,050	
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	810,000	810,000	
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	866,730	866,730	
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.002562	.003765	
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	2,221	3,263	
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	4,296	6,313	
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	70	500	Total vaccinations for all payors
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	61.37	12.63	Cost per injection
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	50	150	Total vaccinations for Medicare patients
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	3,069	1,895	
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)		10,609	
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)		4,964	to WS M-3

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

PROVIDER NO: 50-1300
 COMPONENT NO: 50-0000
 PERIOD: FROM 1/1/2008 TO 12/31/2008
 PREPARED 10/10/2009
 WORKSHEET M-5
 Corresponds to WS E-1

RHC 1

DESCRIPTION	PART MM/DD/YYYY	B AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		400,000
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)		NONE
ADJUSTMENTS TO PROVIDER .01	10/30/2007	1,500
ADJUSTMENTS TO PROVIDER .02		
ADJUSTMENTS TO PROVIDER .03		
ADJUSTMENTS TO PROVIDER .04		
ADJUSTMENTS TO PROVIDER .05		
ADJUSTMENTS TO PROGRAM .50		
ADJUSTMENTS TO PROGRAM .51		
ADJUSTMENTS TO PROGRAM .52		
ADJUSTMENTS TO PROGRAM .53		
ADJUSTMENTS TO PROGRAM .54		
ADJUSTMENTS TO PROGRAM .99		
SUBTOTAL		1,500
4 TOTAL INTERIM PAYMENTS		401,500
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		
TENTATIVE TO PROGRAM .99		
SUBTOTAL		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		10,200
7 TOTAL MEDICARE PROGRAM LIABILITY		391,300

Payments to RHC I

Lump Sum Adjustments

Payments to Medicare

Net Reimbursement from PS&R

Total interim payments, to WS M-3

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.