

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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	15-1331	I	FROM 1/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/15/2009 TIME 17:01

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:
HARRISON COUNTY HOSPITAL 15-1331
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.

[Signature]

OFFICER OR ADMINISTRATOR OF PROVIDER(S)
Chief Financial officer

TITLE
5/29/09

DATE

ECR ENCRYPTION INFORMATION
DATE: 5/15/2009 TIME 17:01

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DATE: 5/15/2009 TIME 17:01

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PART II - SETTLEMENT SUMMARY

	TITLE V		TITLE XVIII		TITLE XIX
	1	A 2	B 3	4	
1	HOSPITAL	0	2,083,133	1,447,479	0
7	HOSPITAL-BASED HHA	0	0	0	0
100	TOTAL	0	2,083,133	1,447,479	0

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 245 ATWOOD ST.
 1 CITY: CORYDON

P.O. BOX:
 STATE: IN ZIP CODE: 47112- COUNTY: HARRISON

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V 4	XVIII 5	XIX 6
02.00 HOSPITAL	HARRISON COUNTY HOSPITAL	15-1331		12/15/2005	N	O	O
09.00 HOSPITAL-BASED HHA	HARRISON COUNTY HHA	15-7242		12/23/1992	N	P	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2008 TO: 12/31/2008
 18 TYPE OF CONTROL 1 2
 9

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? 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 N 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 SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. N
 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
 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 IN COL. 3. / / / /
- 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION 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 IN COL. 3. / / / /
- 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /
- 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) in column 3 (mm/dd/yyyy) / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /
- 25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N
- 25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?
- 25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.
- 25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N
- 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
- 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS) N N

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS) N N
 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. N / /
 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
 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 0.0000 0.0000
 0.00 0

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

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

IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N
 30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) Y
 30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 N
 30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N
 30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBLIE 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 ELIBLIE 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

36 PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL V XVIII XIX
 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) 1 2 3
 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE N N N

37 WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N N
 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?

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

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

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

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

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

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

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

53.01 MDH PERIOD: BEGINNING: / / ENDING: / /
 54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 164,441
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0

54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.

	DATE	Y OR N	LIMIT	Y OR N	FEE
	0	1	2	3	4
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.		Y	0.00	N	0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
 58 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

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

0

MULTICAMPUS

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

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

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00
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).

/ /

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS / TOTAL TITLE XIX
1 ADULTS & PEDIATRICS	21	7,686	89,328.00	3	4	2,874	5
2 HMO							183
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	21	7,686	89,328.00			2,874	183
6 INTENSIVE CARE UNIT	4	1,464	11,064.00			289	63
11 NURSERY							236
12 TOTAL	25	9,150	100,392.00			3,163	482
13 RPCH VISITS							
18 HOME HEALTH AGENCY						1,532	685
25 TOTAL	25						
26 OBSERVATION BED DAYS							125
27 AMBULANCE TRIPS						1,733	
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX OBSERVATION BEDS ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	/ TRIPS / TOTAL OBSERVATION BEDS ADMITTED	DISCHARGES / TITLE XVIII	DISCHARGES / TITLE XIX	DISCHARGES / TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			4,807				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			4,807				
6 INTENSIVE CARE UNIT			461				
11 NURSERY			413				
12 TOTAL			5,681				
13 RPCH VISITS							
18 HOME HEALTH AGENCY			4,912				
25 TOTAL							
26 OBSERVATION BED DAYS	19	106	871	34	837		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET	FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	TITLE V	DISCHARGES / TITLE XVIII	DISCHARGES / TITLE XIX	DISCHARGES / TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					863	181	1,555
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		366.24			863	181	1,555
13 RPCH VISITS							
18 HOME HEALTH AGENCY		6.51					
25 TOTAL		372.75					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
I 15-1331 I FROM 1/ 1/2008 I WORKSHEET S-4
I HHA NO: I TO 12/31/2008 I
I 15-7242 I I
COUNTY:

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	0	0	0
2 UNDUPLICATED CENSUS COUNT		111.00		
	TOTAL 5			

1 HOME HEALTH AIDE HOURS
2 UNDUPLICATED CENSUS COUNT

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES
(FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK

HHA NO. OF FTE EMPLOYEES (2080 HRS)

STAFF 1	CONTRACT 2	TOTAL 3
------------	---------------	------------

- 3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)
- 4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)
- 5 OTHER ADMINISTRATIVE PERSONEL
- 6 DIRECTING NURSING SERVICE
- 7 NURSING SUPERVISOR
- 8 PHYSICAL THERAPY SERVICE
- 9 PHYSICAL THERAPY SUPERVISOR
- 10 OCCUPATIONAL THERAPY SERVICE
- 11 OCCUPATIONAL THERAPY SUPERVISOR
- 12 SPEECH PATHOLOGY SERVICE
- 13 SPEECH PATHOLOGY SUPERVISOR
- 14 MEDICAL SOCIAL SERVICE
- 15 MEDICAL SOCIAL SERVICE SUPERVISOR
- 16 HOME HEALTH AIDE
- 17 HOME HEALTH AIDE SUPERVISOR

HOME HEALTH AGENCY MSA CODES 1 1.01

- 19 HOW MANY MSAS IN COL. 1 OR CBSAS IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD? 0 0
- 20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON OR AFTER OCTOBER 1, 2000

	FULL EPISODES		LUPA	PEP ONLY
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	EPISODES 3	EPISODES 4
21 SKILLED NURSING VISITS	620	0	18	0
22 SKILLED NURSING VISIT CHARGES	119,950	0	5,232	0
23 PHYSICAL THERAPY VISITS	589	0	5	0
24 PHYSICAL THERAPY VISIT CHARGES	118,915	0	878	0
25 OCCUPATIONAL THERAPY VISITS	47	0	0	0
26 OCCUPATIONAL THERAPY VISIT CHARGES	12,599	0	0	0
27 SPEECH PATHOLOGY VISITS	0	0	0	0
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	0	0
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0	0
31 HOME HEALTH AIDE VISITS	252	0	1	0
32 HOME HEALTH AIDE VISIT CHARGES	21,232	0	80	0
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	1,508	0	24	0
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	272,696	0	6,190	0
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	0	0
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	7,799	0	793	0

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
I 15-1331 I FROM 1/ 1/2008 I WORKSHEET S-4
I HHA NO: I TO 12/31/2008 I
I 15-7242 I
COUNTY:

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

PS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
OR AFTER OCTOBER 1, 2000

	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21 SKILLED NURSING VISITS	0	0	638
22 SKILLED NURSING VISIT CHARGES	0	0	125,182
23 PHYSICAL THERAPY VISITS	0	0	594
24 PHYSICAL THERAPY VISIT CHARGES	0	0	119,793
25 OCCUPATIONAL THERAPY VISITS	0	0	47
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	0	12,599
27 SPEECH PATHOLOGY VISITS	0	0	0
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	0
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31 HOME HEALTH AIDE VISITS	0	0	253
32 HOME HEALTH AIDE VISIT CHARGES	0	0	21,312
33 TOTAL VISITS (SUM OF LNS 21,23,25,27,29 & 31)	0	0	1,532
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	278,886
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	0
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	8,592

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET S-10
 I I TO 12/31/2008 I
 I I I

DESCRIPTION

- UNCOMPENSATED CARE INFORMATION
- 1 DO YOU HAVE A WRITTEN CHARITY CARE POLICY?
 - 2 ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04
 - 2.01 IS IT AT THE TIME OF ADMISSION?
 - 2.02 IS IT AT THE TIME OF FIRST BILLING?
 - 2.03 IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?
 - 2.04
 - 3 ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?
 - 4 ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?
 - 5 ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?
 - 6 ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?
 - 7 ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?
 - 8 DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01
 - 8.01 DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?
 - 9 IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04
 - 9.01 IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?
 - 9.02 IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?
 - 9.03 IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?
 - 9.04 IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?
 - 10 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?
 - 11 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04
 - 11.01 IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?
 - 11.02 IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?
 - 11.03 IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?
 - 11.04 IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?
 - 12 ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?
 - 13 IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?
 - 14 IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02
 - 14.01 DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?
 - 14.02 WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?
 - 15 DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?
 - 16 ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?
- UNCOMPENSATED CARE REVENUES
- 17 REVENUE FROM UNCOMPENSATED CARE
 - 17.01 GROSS MEDICAID REVENUES
 - 18 REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS
 - 19 REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)
 - 20 RESTRICTED GRANTS
 - 21 NON-RESTRICTED GRANTS
 - 22 TOTAL GROSS UNCOMPENSATED CARE REVENUES
- UNCOMPENSATED CARE COST
- 23 TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS
 - 24 COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103) .422640
 - 25 TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)
 - 26 TOTAL SCHIP CHARGES FROM YOUR RECORDS
 - TOTAL SCHIP COST, (LINE 24 * LINE 26)
 - TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS 8,790,751

HOSPITAL UNCOMPENSATED CARE DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/15/2009
I	15-1331	I	FROM 1/ 1/2008	I	WORKSHEET S-10
I		I	TO 12/31/2008	I	
I		I		I	

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	3,715,323
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	8,256,956
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	3,489,720
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	3,715,323

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 15-1331
I

I PERIOD:
I FROM 1/ 1/2008 I
I TO 12/31/2008 I
I PREPARED 5/15/2009
I WORKSHEET A

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		2,064,299	2,064,299	1,220,965	3,285,264
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		2,645,365	2,645,365	44,158	2,689,523
5	0500 EMPLOYEE BENEFITS	141,209	3,941,095	4,082,304		4,082,304
6	0600 ADMINISTRATIVE & GENERAL	1,885,887	2,553,578	4,439,465	7,350	4,446,815
8	0800 OPERATION OF PLANT	266,896	1,325,783	1,592,679	148,732	1,741,411
9	0900 LAUNDRY & LINEN SERVICE	23,322	156,920	180,242		180,242
10	1000 HOUSEKEEPING	417,650	217,618	635,268		635,268
11	1100 DIETARY	375,611	621,378	996,989	-727,575	269,414
12	1200 CAFETERIA				727,575	727,575
14	1400 NURSING ADMINISTRATION	784,994	385,438	1,170,432		1,170,432
15	1500 CENTRAL SERVICES & SUPPLY	251,845	49,010	300,855	14,171	315,026
16	1600 PHARMACY					
17	1700 MEDICAL RECORDS & LIBRARY	568,189	158,640	726,829		726,829
18	1800 SOCIAL SERVICE	116,291	4,951	121,242		121,242
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	2,202,985	679,129	2,882,114	-178,967	2,703,147
26	2600 INTENSIVE CARE UNIT	501,823	133,535	635,358	-38,403	596,955
33	3300 NURSERY		2,744	2,744	57,975	60,719
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	874,462	1,127,891	2,002,353	-581,865	1,420,488
40	4000 ANESTHESIOLOGY	638,372	280,738	919,110	-36,367	882,743
41	4100 RADIOLOGY-DIAGNOSTIC	998,838	696,515	1,695,353	-144,861	1,550,492
44	4400 LABORATORY	697,120	1,068,035	1,765,155	-119,481	1,645,674
49	4900 RESPIRATORY THERAPY		537,264	537,264	-92,476	444,788
50	5000 PHYSICAL THERAPY	143,180	134,534	277,714	-2,626	275,088
51	5100 OCCUPATIONAL THERAPY		34,510	34,510		34,510
52	5200 SPEECH PATHOLOGY		19,635	19,635		19,635
53	5300 ELECTROCARDIOLOGY	236,024	176,334	412,358	44,778	457,136
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS				1,315,168	1,315,168
56	5600 DRUGS CHARGED TO PATIENTS	291,128	1,292,808	1,583,936		1,583,936
	OUTPAT SERVICE COST CNTRS					
61	6100 EMERGENCY	1,001,444	1,510,084	2,511,528	-154,209	2,357,319
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES	1,484,292	492,442	1,976,734	-121,926	1,854,808
71	7100 HOME HEALTH AGENCY	313,200	120,188	433,388	-7,350	426,038
88	8800 INTEREST EXPENSE		1,140,408	1,140,408	-1,140,408	
95	SUBTOTALS	14,214,762	23,570,869	37,785,631	234,358	38,019,989
	NONREIMBURS COST CENTERS					
9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
9800	PHYSICIANS' PRIVATE OFFICES	2,571,056	1,017,333	3,588,389	-223,136	3,365,253
99	9900 NONPAID WORKERS					
100	7950 MARKETING	32,224	295,985	328,209	-11,222	316,987
100.01	7951 PHYSICIAN BILLING	211,799	263,595	475,394		475,394
101	TOTAL	17,029,841	25,147,782	42,177,623	-0-	42,177,623

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 15-1331
I

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

I PREPARED 5/15/2009
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-334,633	2,950,631
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-158,610	2,530,913
5	0500 EMPLOYEE BENEFITS	-33,091	4,049,213
6	0600 ADMINISTRATIVE & GENERAL	-58,215	4,388,600
8	0800 OPERATION OF PLANT	-205,831	1,535,580
9	0900 LAUNDRY & LINEN SERVICE		180,242
10	1000 HOUSEKEEPING		635,268
11	1100 DIETARY	-6,812	262,602
12	1200 CAFETERIA	-111,723	615,852
14	1400 NURSING ADMINISTRATION	-223,777	946,655
15	1500 CENTRAL SERVICES & SUPPLY		315,026
16	1600 PHARMACY		
17	1700 MEDICAL RECORDS & LIBRARY	-10,685	716,144
18	1800 SOCIAL SERVICE		121,242
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-160,846	2,542,301
26	2600 INTENSIVE CARE UNIT		596,955
33	3300 NURSERY		60,719
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		1,420,488
40	4000 ANESTHESIOLOGY	-837,163	45,580
41	4100 RADIOLOGY-DIAGNOSTIC		1,550,492
44	4400 LABORATORY	-4,800	1,640,874
49	4900 RESPIRATORY THERAPY		444,788
50	5000 PHYSICAL THERAPY		275,088
51	5100 OCCUPATIONAL THERAPY		34,510
52	5200 SPEECH PATHOLOGY		19,635
53	5300 ELECTROCARDIOLOGY	-107,340	349,796
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,315,168
56	5600 DRUGS CHARGED TO PATIENTS	-2,909	1,581,027
	OUTPAT SERVICE COST CNTRS		
61	6100 EMERGENCY	-1,195,158	1,162,161
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES	-6,000	1,848,808
71	7100 HOME HEALTH AGENCY		426,038
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
95	SUBTOTALS	-3,457,593	34,562,396
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		3,365,253
99	9900 NONPAID WORKERS		
100	7950 MARKETING		316,987
100.01	7951 PHYSICIAN BILLING		475,394
101	TOTAL	-3,457,593	38,720,030

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
4	NEW CAP REL COSTS-BLDG & FIXT	0300	
5	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
	PHYSICIANS' PRIVATE OFFICES	9800	
	NONPAID WORKERS	9900	
100	MARKETING	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	PHYSICIAN BILLING	7951	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO: 151331	PERIOD: FROM 1/ 1/2008 TO 12/31/2008	PREPARED 5/15/2009 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1) COST CENTER	2	LINE NO	SALARY	OTHER
	1		3	4	5
1 EKG	A	ELECTROCARDIOLOGY	53	2,512	
2		ELECTROCARDIOLOGY	53		44,200
3					
4					
5 MED SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		1,315,168
6		CENTRAL SERVICES & SUPPLY	15		14,171
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17 INTEREST	C	NEW CAP REL COSTS-BLDG & FIXT	3		1,140,408
18 CAFETERIA	D	CAFETERIA	12	274,111	
19		CAFETERIA	12		453,464
20 NURSERY	E	NURSERY	33	60,336	
21 OTHER CAPITAL COSTS	F	NEW CAP REL COSTS-MVBLE EQUIP	4		44,158
22 HOME HEALTH MALPRACTICE	G	ADMINISTRATIVE & GENERAL	6		7,350
23 DEPRECIATION AND UTILITIES	H	NEW CAP REL COSTS-BLDG & FIXT	3		124,715
24		OPERATION OF PLANT	8		148,732
25					
36 TOTAL RECLASSIFICATIONS				336,959	3,292,366

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

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151331	FROM 1/ 1/2008	5/15/2009
	TO 12/31/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE			A-7 REF 10
			LINE NO	SALARY	OTHER	
	1	6	7	8	9	
1 EKG	A	AMBULANCE SERVICES	65	141		
2		EMERGENCY	61	1,383		
3		INTENSIVE CARE UNIT	26	988		
4		RESPIRATORY THERAPY	49		44,200	
5 MED SUPPLIES	B	ADULTS & PEDIATRICS	25		118,631	
6		INTENSIVE CARE UNIT	26		37,415	
7		NURSERY	33		2,361	
8		OPERATING ROOM	37		581,865	
9		ANESTHESIOLOGY	40		36,367	
10		RADIOLOGY-DIAGNOSTIC	41		144,861	
11		LABORATORY	44		119,481	
12		RESPIRATORY THERAPY	49		48,276	
13		PHYSICAL THERAPY	50		2,626	
14		ELECTROCARDIOLOGY	53		1,934	
15		EMERGENCY	61		152,826	
16		AMBULANCE SERVICES	65		82,696	
17 INTEREST	C	INTEREST EXPENSE	88		1,140,408	11
18 CAFETERIA	D	DIETARY	11	274,111		
19		DIETARY	11		453,464	
20 NURSERY	E	ADULTS & PEDIATRICS	25	60,336		
21 OTHER CAPITAL COSTS	F	NEW CAP REL COSTS-BLDG & FIXT	3		44,158	9
22 HOME HEALTH MALPRACTICE	G	HOME HEALTH AGENCY	71		7,350	
23 DEPRECIATION AND UTILITIES	H	AMBULANCE SERVICES	65		39,089	9
24		PHYSICIANS' PRIVATE OFFICES	98		223,136	
25		MARKETING	100		11,222	
36 TOTAL RECLASSIFICATIONS				336,959	3,292,366	

(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

RECLASS CODE: A
EXPLANATION : EKG

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	ELECTROCARDIOLOGY	53	2,512	AMBULANCE SERVICES	65	141	
2.00	ELECTROCARDIOLOGY	53	44,200	EMERGENCY	61	1,383	
3.00			0	INTENSIVE CARE UNIT	26	988	
4.00			0	RESPIRATORY THERAPY	49	44,200	
TOTAL RECLASSIFICATIONS FOR CODE A			46,712				46,712

RECLASS CODE: B
EXPLANATION : MED SUPPLIES

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	1,315,168	ADULTS & PEDIATRICS	25	118,631	
2.00	CENTRAL SERVICES & SUPPLY	15	14,171	INTENSIVE CARE UNIT	26	37,415	
3.00			0	NURSERY	33	2,361	
4.00			0	OPERATING ROOM	37	581,865	
5.00			0	ANESTHESIOLOGY	40	36,367	
6.00			0	RADIOLOGY-DIAGNOSTIC	41	144,861	
7.00			0	LABORATORY	44	119,481	
8.00			0	RESPIRATORY THERAPY	49	48,276	
9.00			0	PHYSICAL THERAPY	50	2,626	
10.00			0	ELECTROCARDIOLOGY	53	1,934	
11.00			0	EMERGENCY	61	152,826	
12.00			0	AMBULANCE SERVICES	65	82,696	
TOTAL RECLASSIFICATIONS FOR CODE B			1,329,339				1,329,339

RECLASS CODE: C
EXPLANATION : INTEREST

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	1,140,408	INTEREST EXPENSE	88	1,140,408	
TOTAL RECLASSIFICATIONS FOR CODE C			1,140,408				1,140,408

RECLASS CODE: D
EXPLANATION : CAFETERIA

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	CAFETERIA	12	274,111	DIETARY	11	274,111	
2.00	CAFETERIA	12	453,464	DIETARY	11	453,464	
TOTAL RECLASSIFICATIONS FOR CODE D			727,575				727,575

RECLASS CODE: E
EXPLANATION : NURSERY

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	NURSERY	33	60,336	ADULTS & PEDIATRICS	25	60,336	
TOTAL RECLASSIFICATIONS FOR CODE E			60,336				60,336

RECLASS CODE: F
EXPLANATION : OTHER CAPITAL COSTS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	44,158	NEW CAP REL COSTS-BLDG & FIXT	3	44,158	
TOTAL RECLASSIFICATIONS FOR CODE F			44,158				44,158

RECLASS CODE: G
EXPLANATION : HOME HEALTH MALPRACTICE

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	7,350	HOME HEALTH AGENCY	71	7,350	
TOTAL RECLASSIFICATIONS FOR CODE G			7,350				7,350

RECLASS CODE: H
EXPLANATION : DEPRECIATION AND UTILITIES

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	124,715	AMBULANCE SERVICES	65	39,089	

PROVIDER NO:	PERIOD:	PREPARED
151331	FROM 1/ 1/2008	5/15/2009
	TO 12/31/2008	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASSIFICATIONS

RECLASS CODE: H
 EXPLANATION : DEPRECIATION AND UTILITIES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	AMOUNT
2.00	OPERATION OF PLANT	8	148,732	PHYSICIANS' PRIVATE OFFICES	98	223,136	
3.00			0	MARKETING	100	11,222	
TOTAL RECLASSIFICATIONS FOR CODE H			273,447			273,447	

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	895,186	2,306,074			2,306,074	6,000	3,195,260	
2	LAND IMPROVEMENTS	867,101	3,145,429			3,145,429	571,426	3,441,104	
3	BUILDINGS & FIXTURE	15,186,703	33,259,580			33,259,580	13,433,899	35,012,384	
4	BUILDING IMPROVEMEN								
5	FIXED EQUIPMENT								
6	MOVABLE EQUIPMENT	13,609,288	7,644,645			7,644,645	3,437,690	17,816,243	
7	SUBTOTAL	30,558,278	46,355,728			46,355,728	17,449,015	59,464,991	
8	RECONCILING ITEMS								
9	TOTAL	30,558,278	46,355,728			46,355,728	17,449,015	59,464,991	

III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS CAPITIALIZED GROSS ASSETS		ALLOCATION OF OTHER CAPITAL			TOTAL 8
			LEASES 2	FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	
3	NEW CAP REL COSTS-BL	38,453,487		38,453,487	.683378			
4	NEW CAP REL COSTS-MV	17,816,243		17,816,243	.316622			
5	TOTAL	56,269,730		56,269,730	1.000000			

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
3	NEW CAP REL COSTS-BL	2,144,856		805,775				2,950,631
4	NEW CAP REL COSTS-MV	2,683,853		-152,940				2,530,913
5	TOTAL	4,828,709		652,835				5,481,544

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
3	NEW CAP REL COSTS-BL	2,064,299						2,064,299
4	NEW CAP REL COSTS-MV	2,645,365						2,645,365
5	TOTAL	4,709,664						4,709,664

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I 15-1331 I

I PERIOD: I PREPARED 5/15/2009 I FROM 1/ 1/2008 I WORKSHEET A-8 I TO 12/31/2008 I

DESCRIPTION (1)	(2)		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			WKST. A-7 REF. 5
	BASIS/CODE 1	AMOUNT 2	COST CENTER 3	LINE NO 4		
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1		
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2		
3 INVST INCOME-NEW BLDGS AND FIXTURES	B	-332,583	NEW CAP REL COSTS-BLDG &	3	11	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-152,940	NEW CAP REL COSTS-MVBLE E	4	11	
5 INVESTMENT INCOME-OTHER						
6 TRADE, QUANTITY AND TIME DISCOUNTS	B	-3,302	ADMINISTRATIVE & GENERAL	6		
7 REFUNDS AND REBATES OF EXPENSES						
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS						
9 TELEPHONE SERVICES	A	-3,933	ADMINISTRATIVE & GENERAL	6		
10 TELEVISION AND RADIO SERVICE						
11 PARKING LOT						
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-2,225,847				
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1					
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-111,723	CAFETERIA	12		
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS						
18 SALE OF MED AND SURG SUPPLIES	B	-10,685	MEDICAL RECORDS & LIBRARY	17		
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-2,909	DRUGS CHARGED TO PATIENTS	56		
20 SALE OF MEDICAL RECORDS & ABSTRACTS						
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)						
22 VENDING MACHINES						
23 INCOME FROM IMPOSITION OF INTEREST						
24 INTRST EXP ON MEDICARE OVERPAYMENTS						
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49		
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50		
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3					
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89		
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1		
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2		
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3		
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4		
33 NON-PHYSICIANS ANESTHETIST			**COST CENTER DELETED**	20		
34 PHYSICIANS' ASSISTANT						
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51		
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52		
37 OTHER ADJUSTMENTS (SPECIFY)						
38 OTHER ADJUSTMENTS (SPECIFY)						
39 BUS TB TESTIN REV	B	-2,355	EMPLOYEE BENEFITS	5		
CPR&EMS REV	B	-22,129	ADMINISTRATIVE & GENERAL	6		
MISC REV	B	-11,012	ADMINISTRATIVE & GENERAL	6		
42 MED STAFF FEES	B	-6,450	ADMINISTRATIVE & GENERAL	6		
43 OTHER ADJUSTMENTS (SPECIFY)						
44 DIETARY SALES TAX	A	-6,812	DIETARY	11		
45 OTHER ADJUSTMENTS (SPECIFY)						
46 PATIENT PHONE SALARIES	A	-3,700	ADMINISTRATIVE & GENERAL	6		
47 PATIENT PHONE DEPRECIATION	A	-5,670	NEW CAP REL COSTS-MVBLE E	4	9	
48 CRNA CONTRACTED SERVICES	A	-198,791	ANESTHESIOLOGY	40		
49 UNNECESSARY BORROWING	A	-2,050	NEW CAP REL COSTS-BLDG &	3	11	
49.01 PHYSICIAN BILLING	B	-7,689	ADMINISTRATIVE & GENERAL	6		
49.02 ADJ #1	A	-30,736	EMPLOYEE BENEFITS	5		
49.03 PLANT MAINTENANCE	A	-205,831	OPERATION OF PLANT	8		
49.04 ADJ #2, POSTED 5/1/09	A	-110,446	ADULTS & PEDIATRICS	25		
50 TOTAL (SUM OF LINES 1 THRU 49)		-3,457,593				

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET A-8-2
 I I TO 12/31/2008 I GROUP 1

WKSHT A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN- ERATION 3	PROFES- SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	25 OB	50,400	50,400					
2	61 ER	1,195,158	1,195,158					
3	65 AMBULANCE	6,000	6,000					
4	44 LAB	48,000	4,800	43,200				
5	53 EKG	107,340	107,340					
6	14 MED STAFF DEVELOPMENT	223,777	223,777					
7	40 ANESTHESIA	638,372	638,372					
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	2,269,047	2,225,847	43,200				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I
I 15-1331 I
I I

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

I PREPARED 5/15/2009 I
I WORKSHEET A-8-2 I
I GROUP 1 I

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	25	OB						50,400
2	61	ER						1,195,158
3	65	AMBULANCE						6,000
4	44	LAB						4,800
5	53	EKG						107,340
6	14	MED STAFF DEVELOPMENT						223,777
7	40	ANESTHESIA						638,372
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						2,225,847

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

I PROVIDER NO: I 15-1331 I

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

I PREPARED 5/15/2009 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

- 1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) 52
(SEE INSTRUCTIONS)
- 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)
- 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 4.85
- 8 OPTIONAL TRAVEL EXPENSE RATE PER MILE

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9 TOTAL HOURS WORKED		2487.57	300.51		
10 AHSEA (SEE INSTRUCTIONS)		67.24	50.43		
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	33.62	33.62	25.22		
12 NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01 NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13 NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)		81			
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) 167,264
- 16 ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10) 15,155
- 17 SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS) 182,419
- 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) 182,419

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) 182,419

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)
- 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)

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

I PROVIDER NO: I 15-1331 I

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

I PREPARED 5/15/2009 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

- STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
- 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

	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
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)	182,419
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)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	182,419
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	127,591

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

I PROVIDER NO: I 15-1331 I

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

I PREPARED 5/15/2009 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

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)	101,760
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	25,831
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	127,591
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	.797548
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	.202452
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO: I 15-1331
 I

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

I PREPARED 5/15/2009
 I WORKSHEET A-8-4
 I PARTS I - VII

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

- 1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)
(SEE INSTRUCTIONS)
- 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 4.85
- 8 OPTIONAL TRAVEL EXPENSE RATE PER MILE

SUPERVISORS THERAPISTS ASSISTANTS AIDES TRAINEES

- 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)

	1	2	3	4	5
9		794.03			
10		63.74			
11	31.87	31.87			

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) 50,611
- 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) 50,611
- 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) 50,611

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) 50,611

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)
- 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)

35 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 50,611
 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)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 50,611
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 43,167

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

I PROVIDER NO: I 15-1331 I

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

I PREPARED 5/15/2009 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

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)	34,459
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	8,708
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	43,167
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	.798272
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	.201728
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

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

I PROVIDER NO: I 15-1331 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 5/15/2009 I WORKSHEET A-8-4 I PARTS I - VII

SPEECH PATHOLOGY

RT 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 4.85
- 8 OPTIONAL TRAVEL EXPENSE RATE PER MILE

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9 TOTAL HOURS WORKED		334.51			
10 AHSEA (SEE INSTRUCTIONS)		75.26			
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	37.63	37.63			

- 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) 25,175
- 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) 25,175
- 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) 25,175

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) 25,175

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)
- 31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
- 32 OPTIONAL TRAVEL EXPENSE (LN 8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)

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

I PROVIDER NO: I 15-1331 I

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

I PREPARED 5/15/2009 I WORKSHEET A-8-4 I PARTS I - VII

SPEECH PATHOLOGY

- 4 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
- OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
- 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56) OVERTIME RATE (SEE INSTRUCTIONS)					
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)	25,175
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)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	25,175
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	18,311

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

I PROVIDER NO: I 15-1331 I

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

I PREPARED 5/15/2009 I WORKSHEET A-8-4 I PARTS I - VII

SPEECH PATHOLOGY

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)	18,311
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	18,311
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 12/31/2008 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
	NEW CAP REL COSTS-MVBLE EQUIP	4	SQUARE FEET	ENTERED
	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	4	SQUARE FEET	ENTERED
11	DIETARY	11	PATIENT DAYS	ENTERED
12	CAFETERIA	12	HOURS OF SERVICE	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	ENTERED
16	PHARMACY	15	COSTED REQUIS.	NOT ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	ENTERED
18	SOCIAL SERVICE	11	PATIENT DAYS	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET B
 I TO 12/31/2008 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	3	4	5	5a.00	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	2,950,631	2,950,631					
005 NEW CAP REL COSTS-MVBLE E	2,530,913		2,530,913				
006 EMPLOYEE BENEFITS	4,049,213	4,276	3,997	4,057,486			
008 ADMINISTRATIVE & GENERAL	4,388,600	403,435	377,169	453,084	5,622,288	5,622,288	
009 OPERATION OF PLANT	1,535,580	331,251	309,685	64,122	2,240,638	380,615	2,621,253
010 LAUNDRY & LINEN SERVICE	180,242	24,999	23,372	5,603	234,216	39,786	29,629
011 HOUSEKEEPING	635,268	37,259	34,833	100,340	807,700	137,203	44,159
012 DIETARY	262,602	120,830	112,963	24,385	520,780	88,464	143,206
014 CAFETERIA	615,852	57,721	53,963	65,855	793,391	134,773	68,410
015 NURSING ADMINISTRATION	946,655	10,973	10,258	188,595	1,156,481	196,450	13,005
016 CENTRAL SERVICES & SUPPLY PHARMACY	315,026			60,506	375,532	63,791	
017 MEDICAL RECORDS & LIBRARY	716,144	64,920	60,693	136,507	978,264	166,177	76,942
018 SOCIAL SERVICE	121,242	3,599		27,939	152,780	25,953	4,266
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	2,542,301	483,818	455,686	514,771	3,996,576	678,894	573,422
033 INTENSIVE CARE UNIT	596,955	61,277	57,287	120,326	835,845	141,984	72,624
033 NURSERY	60,719	12,325	11,523	14,496	99,063	16,828	14,608
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	1,420,488	334,458	312,683	210,089	2,277,718	386,914	396,396
041 ANESTHESIOLOGY	45,580			153,369	198,949	33,795	
044 RADIOLOGY-DIAGNOSTIC	1,550,492	190,985	178,551	239,971	2,159,999	366,917	226,353
049 LABORATORY	1,640,874	97,794	91,427	167,483	1,997,578	339,327	115,904
050 RESPIRATORY THERAPY	444,788	22,578	21,108		488,474	82,977	26,759
051 PHYSICAL THERAPY	275,088	74,932	70,054	34,399	454,473	77,201	88,809
052 OCCUPATIONAL THERAPY	34,510				34,510	5,862	
053 SPEECH PATHOLOGY	19,635				19,635	3,335	
055 ELECTROCARDIOLOGY	349,796	36,735	34,344	57,308	478,183	81,228	43,538
056 MEDICAL SUPPLIES CHARGED	1,315,168	92,384	86,369		1,493,921	253,771	109,492
061 DRUGS CHARGED TO PATIENTS	1,581,027	25,741	24,065	69,944	1,700,777	288,909	30,508
062 OUTPAT SERVICE COST CNTRS							
063 EMERGENCY	1,162,161	128,966	120,570	240,265	1,651,962	280,617	152,850
065 OBSERVATION BEDS (NON-DIS							
071 OTHER OUTPATIENT SERVICE							
095 OTHER REIMBURS COST CNTRS							
095 AMBULANCE SERVICES	1,848,808	18,717	17,498	356,567	2,241,590	380,777	22,183
071 HOME HEALTH AGENCY	426,038	31,304	29,266	75,246	561,854	95,442	37,101
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	34,562,396	2,671,277	2,497,364	3,381,170	33,573,177	4,747,990	2,290,164
095 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP		20,396	19,069		39,465	6,704	24,174
099 PHYSICIANS' PRIVATE OFFIC	3,365,253	243,470		617,689	4,226,412	717,944	288,559
100 NONPAID WORKERS							
100 MARKETING	316,987	4,581	4,283	7,742	333,593	56,667	5,429
100 01 PHYSICIAN BILLING	475,394	10,907	10,197	50,885	547,383	92,983	12,927
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	38,720,030	2,950,631	2,530,913	4,057,486	38,720,030	5,622,288	2,621,253

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART I

COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE	303,631						
010 HOUSEKEEPING	10,933	999,995					
011 DIETARY	5,019	63,396	820,865				
012 CAFETERIA		30,284		1,026,858			
014 NURSING ADMINISTRATION		5,757		48,357	1,420,050		
015 CENTRAL SERVICES & SUPPLY				37,580		476,903	
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		34,061		73,606			
018 SOCIAL SERVICE				8,251		150	
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	145,437	255,736	749,032	157,359	488,335	13,131	
026 INTENSIVE CARE UNIT		32,150	71,833	97,501	302,577	1,730	
033 NURSERY		6,467		5,872	18,224		
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	30,831	175,481		82,179	255,029	22,512	
040 ANESTHESIOLOGY				8,558		1,329	
041 RADIOLOGY-DIAGNOSTIC	32,604	100,204		97,135		5,302	
044 LABORATORY		51,310		78,756		3,967	
049 RESPIRATORY THERAPY	1,165	11,846				1,088	
050 PHYSICAL THERAPY	7,741	39,315		13,678		2,723	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY						1	
053 ELECTROCARDIOLOGY		19,274		21,859		1,815	
055 MEDICAL SUPPLIES CHARGED		48,471				400,096	
056 DRUGS CHARGED TO PATIENTS		13,506		14,922		2,542	
OUTPAT SERVICE COST CNTRS							
061 EMERGENCY	48,449	67,665		84,949	263,623	8,955	
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	12,364	9,820				11,562	
071 HOME HEALTH AGENCY		16,424			92,262		
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	294,543	981,167	820,865	830,562	1,420,050	476,903	
NONREIMBURS COST CENTERS							
GIFT, FLOWER, COFFEE SHOP		10,701					
098 PHYSICIANS' PRIVATE OFFIC	9,088			163,415			
099 NONPAID WORKERS							
100 MARKETING		2,404		4,233			
100 01 PHYSICIAN BILLING		5,723		28,648			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	303,631	999,995	820,865	1,026,858	1,420,050	476,903	

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	18	25	26	27
003 GENERAL SERVICE COST CNTR					
004 NEW CAP REL COSTS-BLDG &					
005 NEW CAP REL COSTS-MVBLE E					
006 EMPLOYEE BENEFITS					
008 ADMINISTRATIVE & GENERAL					
009 OPERATION OF PLANT					
010 LAUNDRY & LINEN SERVICE					
011 HOUSEKEEPING					
012 DIETARY					
014 CAFETERIA					
014 NURSING ADMINISTRATION					
015 CENTRAL SERVICES & SUPPLY					
016 PHARMACY					
017 MEDICAL RECORDS & LIBRARY	1,329,050				
018 SOCIAL SERVICE		191,400			
025 INPAT ROUTINE SRVC CNTRS					
026 ADULTS & PEDIATRICS	86,876	174,651	7,319,449		7,319,449
033 INTENSIVE CARE UNIT	13,298	16,749	1,586,291		1,586,291
033 NURSERY	8,025		169,087		169,087
037 ANCILLARY SRVC COST CNTRS					
040 OPERATING ROOM	134,229		3,761,289		3,761,289
041 ANESTHESIOLOGY	7,537		250,168		250,168
044 RADIOLOGY-DIAGNOSTIC	433,710		3,422,224		3,422,224
049 LABORATORY	177,698		2,764,540		2,764,540
050 RESPIRATORY THERAPY	39,886		652,195		652,195
051 PHYSICAL THERAPY	30,633		714,573		714,573
052 OCCUPATIONAL THERAPY	2,505		42,877		42,877
053 SPEECH PATHOLOGY	885		23,856		23,856
055 ELECTROCARDIOLOGY	45,900		691,797		691,797
056 MEDICAL SUPPLIES CHARGED	66,699		2,372,450		2,372,450
061 DRUGS CHARGED TO PATIENTS	90,796		2,141,960		2,141,960
061 OUTPAT SERVICE COST CNTRS					
062 EMERGENCY	117,582		2,676,652		2,676,652
063 OBSERVATION BEDS (NON-DIS					
063 OTHER OUTPATIENT SERVICE					
065 OTHER REIMBURS COST CNTRS					
071 AMBULANCE SERVICES	72,791		2,751,087		2,751,087
095 HOME HEALTH AGENCY			803,083		803,083
095 SPEC PURPOSE COST CENTERS					
095 SUBTOTALS	1,329,050	191,400	32,143,578		32,143,578
095 NONREIMBURS COST CENTERS					
095 GIFT, FLOWER, COFFEE SHOP			81,044		81,044
095 PHYSICIANS' PRIVATE OFFIC			5,405,418		5,405,418
099 NONPAID WORKERS					
100 MARKETING			402,326		402,326
100 01 PHYSICIAN BILLING			687,664		687,664
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 TOTAL	1,329,050	191,400	38,720,030		38,720,030

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I 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	ADMINISTRATIV E & GENERAL 6	OPERATION OF PLANT 8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 EMPLOYEE BENEFITS		4,276	3,997	8,273	8,273		
006 ADMINISTRATIVE & GENERAL		403,435	377,169	780,604	924	781,528	
008 OPERATION OF PLANT		331,251	309,685	640,936	131	52,908	693,975
009 LAUNDRY & LINEN SERVICE		24,999	23,372	48,371	11	5,531	7,844
010 HOUSEKEEPING		37,259	34,833	72,092	205	19,072	11,691
011 DIETARY		120,830	112,963	233,793	50	12,297	37,914
012 CAFETERIA		57,721	53,963	111,684	134	18,734	18,112
014 NURSING ADMINISTRATION		10,973	10,258	21,231	385	27,308	3,443
015 CENTRAL SERVICES & SUPPLY					123	8,867	
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		64,920	60,693	125,613	278	23,100	20,370
018 SOCIAL SERVICE		3,599		3,599	57	3,608	1,129
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		483,818	455,686	939,504	1,050	94,371	151,814
033 INTENSIVE CARE UNIT		61,277	57,287	118,564	245	19,737	19,227
033 NURSERY		12,325	11,523	23,848	30	2,339	3,867
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM		334,458	312,683	647,141	428	53,784	104,946
041 ANESTHESIOLOGY					313	4,698	
044 RADIOLOGY-DIAGNOSTIC		190,985	178,551	369,536	489	51,004	59,927
044 LABORATORY		97,794	91,427	189,221	342	47,169	30,686
049 RESPIRATORY THERAPY		22,578	21,108	43,686		11,534	7,084
050 PHYSICAL THERAPY		74,932	70,054	144,986	70	10,731	23,512
051 OCCUPATIONAL THERAPY						815	
052 SPEECH PATHOLOGY						464	
053 ELECTROCARDIOLOGY		36,735	34,344	71,079	117	11,291	11,527
055 MEDICAL SUPPLIES CHARGED		92,384	86,369	178,753		35,276	28,988
056 DRUGS CHARGED TO PATIENTS		25,741	24,065	49,806	143	40,160	8,077
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY		128,966	120,570	249,536	490	39,008	40,467
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
065 OTHER REIMBURS COST CNTRS							
071 AMBULANCE SERVICES		18,717	17,498	36,215	727	52,931	5,873
071 HOME HEALTH AGENCY		31,304	29,266	60,570	153	13,267	9,822
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		2,671,277	2,497,364	5,168,641	6,895	660,004	606,320
NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP		20,396	19,069	39,465		932	6,400
098 PHYSICIANS' PRIVATE OFFIC		243,470		243,470	1,258	99,790	76,396
099 NONPAID WORKERS							
100 MARKETING		4,581	4,283	8,864	16	7,877	1,437
100 01 PHYSICIAN BILLING		10,907	10,197	21,104	104	12,925	3,422
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		2,950,631	2,530,913	5,481,544	8,273	781,528	693,975

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART III

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
	9	10	11	12	14	15	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENERAL							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE	61,757						
011 HOUSEKEEPING	2,224	105,284					
012 DIETARY	1,021	6,675	291,750				
014 CAFETERIA		3,188		151,852			
015 NURSING ADMINISTRATION		606		7,151	60,124		
016 CENTRAL SERVICES & SUPPLY				5,557		14,547	
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY		3,586		10,885			
025 SOCIAL SERVICE				1,220			5
026 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	29,581	26,926	266,219	23,270	20,675		401
033 INTENSIVE CARE UNIT		3,385	25,531	14,418	12,811		53
037 NURSERY		681		868	772		
040 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM	6,271	18,475		12,153	10,798		687
044 ANESTHESIOLOGY				1,266			41
049 RADIOLOGY-DIAGNOSTIC	6,631	10,550		14,364			162
050 LABORATORY		5,402		11,646			121
051 RESPIRATORY THERAPY	237	1,247					33
052 PHYSICAL THERAPY	1,575	4,139		2,023			83
053 OCCUPATIONAL THERAPY							
055 SPEECH PATHOLOGY							
056 ELECTROCARDIOLOGY		2,029		3,232			55
061 MEDICAL SUPPLIES CHARGED		5,103				12,202	
062 DRUGS CHARGED TO PATIENTS		1,422		2,207			78
063 OUTPAT SERVICE COST CNTRS							
065 EMERGENCY	9,854	7,124		12,562	11,162		273
071 OBSERVATION BEDS (NON-DIS							
095 OTHER OUTPATIENT SERVICE							
099 OTHER REIMBURS COST CNTRS							
100 AMBULANCE SERVICES	2,515	1,034					353
101 HOME HEALTH AGENCY		1,729			3,906		
102 SPEC PURPOSE COST CENTERS							
103 SUBTOTALS	59,909	103,301	291,750	122,822	60,124		14,547
NONREIMBURS COST CENTERS							
GIFT, FLOWER, COFFEE SHOP		1,127					
PHYSICIANS' PRIVATE OFFIC	1,848			24,167			
NONPAID WORKERS							
MARKETING		253		626			
PHYSICIAN BILLING		603		4,237			
CROSS FOOT ADJUSTMENTS							
NEGATIVE COST CENTER							
TOTAL	61,757	105,284	291,750	151,852	60,124		14,547

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART III

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	18	25	26	27
003 GENERAL SERVICE COST CNTR					
004 NEW CAP REL COSTS-BLDG &					
005 NEW CAP REL COSTS-MVBLE E					
006 EMPLOYEE BENEFITS					
008 ADMINISTRATIVE & GENERAL					
009 OPERATION OF PLANT					
010 LAUNDRY & LINEN SERVICE					
011 HOUSEKEEPING					
012 DIETARY					
014 CAFETERIA					
015 NURSING ADMINISTRATION					
016 CENTRAL SERVICES & SUPPLY					
017 PHARMACY					
018 MEDICAL RECORDS & LIBRARY	183,832				
		9,618			
025 INPAT ROUTINE SRVC CNTRS					
026 ADULTS & PEDIATRICS	12,018	8,776	1,574,605		1,574,605
033 INTENSIVE CARE UNIT	1,840	842	216,653		216,653
	1,110		33,515		33,515
037 ANCILLARY SRVC COST CNTRS					
040 OPERATING ROOM	18,568		873,251		873,251
041 ANESTHESIOLOGY	1,043		7,361		7,361
044 RADIOLOGY-DIAGNOSTIC	59,977		572,640		572,640
049 LABORATORY	24,581		309,168		309,168
050 RESPIRATORY THERAPY	5,518		69,339		69,339
051 PHYSICAL THERAPY	4,238		191,357		191,357
052 OCCUPATIONAL THERAPY	347		1,162		1,162
053 SPEECH PATHOLOGY	122		586		586
055 ELECTROCARDIOLOGY	6,349		105,679		105,679
056 MEDICAL SUPPLIES CHARGED	9,227		269,549		269,549
	12,560		114,453		114,453
061 OUTPAT SERVICE COST CNTRS					
062 EMERGENCY	16,265		386,741		386,741
063 OBSERVATION BEDS (NON-DIS					
065 OTHER OUTPATIENT SERVICE					
071 OTHER REIMBURS COST CNTRS					
	10,069		109,717		109,717
095 AMBULANCE SERVICES			89,447		89,447
098 HOME HEALTH AGENCY					
099 SPEC PURPOSE COST CENTERS					
100 SUBTOTALS	183,832	9,618	4,925,223		4,925,223
101 NONREIMBURS COST CENTERS					
102 GIFT, FLOWER, COFFEE SHOP			47,924		47,924
103 PHYSICIANS' PRIVATE OFFIC			446,929		446,929
099 NONPAID WORKERS					
100 MARKETING			19,073		19,073
100 01 PHYSICIAN BILLING			42,395		42,395
101 CROSS FOOT ADJUSTMENTS					
102 NEGATIVE COST CENTER					
103 TOTAL	183,832	9,618	5,481,544		5,481,544

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET B-1
 I I TO 12/31/2008 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
	OSTS-BLDG & (SQUARE FEET)	OSTS-MVBLE E (SQUARE FEET)	(GROSS SALARIES)		(ACCUM. COST)	(SQUARE FEET)
	3	4	5	6a.00	6	8
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	135,261					
005 NEW CAP REL COSTS-MVB		124,100				
006 EMPLOYEE BENEFITS	196	196	16,888,632			
008 ADMINISTRATIVE & GENE	18,494	18,494	1,885,887	-5,622,288	33,097,742	
009 OPERATION OF PLANT	15,185	15,185	266,896		2,240,638	101,386
010 LAUNDRY & LINEN SERVI	1,146	1,146	23,322		234,216	1,146
011 HOUSEKEEPING	1,708	1,708	417,650		807,700	1,708
012 DIETARY	5,539	5,539	101,500		520,780	5,539
014 CAFETERIA	2,646	2,646	274,111		793,391	2,646
015 NURSING ADMINISTRATIO	503	503	784,994		1,156,481	503
016 CENTRAL SERVICES & SU			251,845		375,532	
017 PHARMACY						
018 MEDICAL RECORDS & LIB	2,976	2,976	568,189		978,264	2,976
025 SOCIAL SERVICE	165		116,291		152,780	165
026 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS	22,179	22,344	2,142,649		3,996,576	22,179
033 INTENSIVE CARE UNIT	2,809	2,809	500,835		835,845	2,809
037 NURSERY	565	565	60,336		99,063	565
040 ANCILLARY SRVC COST C						
041 OPERATING ROOM	15,332	15,332	874,462		2,277,718	15,332
044 ANESTHESIOLOGY			638,372		198,949	
049 RADIOLOGY-DIAGNOSTIC	8,755	8,755	998,838		2,159,999	8,755
050 LABORATORY	4,483	4,483	697,120		1,997,578	4,483
051 RESPIRATORY THERAPY	1,035	1,035			488,474	1,035
052 PHYSICAL THERAPY	3,435	3,435	143,180		454,473	3,435
053 OCCUPATIONAL THERAPY					34,510	
055 SPEECH PATHOLOGY					19,635	
056 ELECTROCARDIOLOGY	1,684	1,684	238,536		478,183	1,684
061 MEDICAL SUPPLIES CHAR	4,235	4,235			1,493,921	4,235
062 DRUGS CHARGED TO PATI	1,180	1,180	291,128		1,700,777	1,180
063 OUTPAT SERVICE COST C						
061 EMERGENCY	5,912	5,912	1,000,061		1,651,962	5,912
062 OBSERVATION BEDS (NON						
063 OTHER OUTPATIENT SERV						
063 OTHER REIMBURS COST C						
095 AMBULANCE SERVICES	858	858	1,484,151		2,241,590	858
096 HOME HEALTH AGENCY	1,435	1,435	313,200		561,854	1,435
098 SPEC PURPOSE COST CEN						
099 SUBTOTALS	122,455	122,455	14,073,553	-5,622,288	27,950,889	88,580
100 NONREIMBURS COST CENT						
101 GIFT, FLOWER, COFFEE	935	935			39,465	935
102 PHYSICIANS' PRIVATE O	11,161		2,571,056		4,226,412	11,161
103 NONPAID WORKERS						
100 MARKETING	210	210	32,224		333,593	210
100 01 PHYSICIAN BILLING	500	500	211,799		547,383	500
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	2,950,631	2,530,913	4,057,486		5,622,288	2,621,253
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	21.814352		.240250		.169869	
105 (WRKSHT B, PT I)		20.394142				25.854191
105 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
107 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED			8,273		781,528	693,975
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER			.000490		.023613	6.844880
108 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY
	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(PATIENT DAYS)	(HOURS OF SERVICE)	(DIRECT NRSING HRS)	(COSTED REQUIS.)	(COSTED REQUIS.)
	9	10	11	12	14	15	16
GENERAL SERVICE COST							
003 NEW CAP REL COSTS-BLD							
004 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE	211,129						
010 HOUSEKEEPING	7,602	87,371					
011 DIETARY	3,490	5,539	5,268				
012 CAFETERIA		2,646		467,937			
014 NURSING ADMINISTRATION		503		22,036	208,523		
015 CENTRAL SERVICES & SUPPLY				17,125		1,567,644	
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY		2,976		33,542			
018 SOCIAL SERVICE				3,760		494	
INPAT ROUTINE SERVICE CENTER							
025 ADULTS & PEDIATRICS	101,130	22,344	4,807	71,708	71,708	43,165	
026 INTENSIVE CARE UNIT		2,809	461	44,431	44,431	5,687	
033 NURSERY		565		2,676	2,676		
ANCILLARY SERVICE COST CENTER							
037 OPERATING ROOM	21,438	15,332		37,449	37,449	74,000	
040 ANESTHESIOLOGY				3,900		4,370	
041 RADIOLOGY-DIAGNOSTIC	22,671	8,755		44,264		17,428	
044 LABORATORY		4,483		35,889		13,039	
049 RESPIRATORY THERAPY	810	1,035				3,576	
050 PHYSICAL THERAPY	5,383	3,435		6,233		8,951	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY						2	
053 ELECTROCARDIOLOGY		1,684		9,961		5,965	
055 MEDICAL SUPPLIES CHARGED TO PATIENT		4,235				1,315,168	
056 DRUGS CHARGED TO PATIENT		1,180		6,800		8,356	
OUTPATIENT SERVICE COST CENTER							
061 EMERGENCY	33,689	5,912		38,711	38,711	29,437	
062 OBSERVATION BEDS (NON-REIMBURSABLE)							
063 OTHER OUTPATIENT SERVICES							
OTHER REIMBURSABLE COST CENTER							
AMBULANCE SERVICES	8,597	858				38,006	
HOME HEALTH AGENCY		1,435			13,548		
SPECIAL PURPOSE COST CENTER							
095 SUBTOTALS	204,810	85,726	5,268	378,485	208,523	1,567,644	
NONREIMBURSABLE COST CENTER							
GIFT, FLOWER, COFFEE		935					
098 PHYSICIANS' PRIVATE OPPORTUNITY	6,319			74,468			
099 NONPAID WORKERS							
100 MARKETING		210		1,929			
0101 PHYSICIAN BILLING		500		13,055			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED (WRKSHT B, PART I)	303,631	999,995	820,865	1,026,858	1,420,050	476,903	
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)	1.438130	11.445388	155.820995	2.194436	6.810040	.304216	
105 COST TO BE ALLOCATED (WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107 COST TO BE ALLOCATED (WRKSHT B, PART III)	61,757	105,284	291,750	151,852	60,124	14,547	
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)	.292508	1.205022	55.381549	.324514	.288333	.009280	

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET B-1
 I I TO 12/31/2008 I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	
(TIME SPENT	(PATIENT)AYS	D)
	17	18	
003 GENERAL SERVICE COST			
004 NEW CAP REL COSTS-BLD			
005 NEW CAP REL COSTS-MVB			
006 EMPLOYEE BENEFITS			
008 ADMINISTRATIVE & GENE			
009 OPERATION OF PLANT			
010 LAUNDRY & LINEN SERVI			
011 HOUSEKEEPING			
012 DIETARY			
014 CAFETERIA			
015 NURSING ADMINISTRATIO			
016 CENTRAL SERVICES & SU			
017 PHARMACY			
018 MEDICAL RECORDS & LIB	73,335,130		
025 SOCIAL SERVICE			5,268
026 INPAT ROUTINE SRVC CN			
033 ADULTS & PEDIATRICS	4,793,704		4,807
037 INTENSIVE CARE UNIT	733,791		461
040 NURSERY	442,785		
041 ANCILLARY SRVC COST C			
044 OPERATING ROOM	7,406,574		
049 ANESTHESIOLOGY	415,858		
050 RADIOLOGY-DIAGNOSTIC	23,931,567		
051 LABORATORY	9,805,115		
052 RESPIRATORY THERAPY	2,200,854		
053 PHYSICAL THERAPY	1,690,298		
055 OCCUPATIONAL THERAPY	138,225		
056 SPEECH PATHOLOGY	48,843		
061 ELECTROCARDIOLOGY	2,532,703		
062 MEDICAL SUPPLIES CHAR	3,680,325		
063 DRUGS CHARGED TO PATI	5,010,004		
061 OUTPAT SERVICE COST C			
062 EMERGENCY	6,487,978		
063 OBSERVATION BEDS (NON			
063 OTHER OUTPATIENT SERV			
063 OTHER REIMBURS COST C			
095 AMBULANCE SERVICES	4,016,506		
095 HOME HEALTH AGENCY			
095 SPEC PURPOSE COST CEN			
095 SUBTOTALS	73,335,130		5,268
096 NONREIMBURS COST CENT			
098 GIFT, FLOWER, COFFEE			
099 PHYSICIANS' PRIVATE O			
100 NONPAID WORKERS			
100 MARKETING			
100 01 PHYSICIAN BILLING			
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 COST TO BE ALLOCATED	1,329,050		191,400
104 (PER WRKSHT B, PART			
104 UNIT COST MULTIPLIER			36.332574
105 (WRKSHT B, PT I)	.018123		
105 COST TO BE ALLOCATED			
106 (PER WRKSHT B, PART			
106 UNIT COST MULTIPLIER			
107 (WRKSHT B, PT II)			
107 COST TO BE ALLOCATED	183,832		9,618
108 (PER WRKSHT B, PART			
108 UNIT COST MULTIPLIER			1.825740
108 (WRKSHT B, PT III)	.002507		

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	7,319,449		7,319,449		7,319,449
26	INTENSIVE CARE UNIT	1,586,291		1,586,291		1,586,291
33	NURSERY	169,087		169,087		169,087
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	3,761,289		3,761,289		3,761,289
40	ANESTHESIOLOGY	250,168		250,168		250,168
41	RADIOLOGY-DIAGNOSTIC	3,422,224		3,422,224		3,422,224
44	LABORATORY	2,764,540		2,764,540		2,764,540
49	RESPIRATORY THERAPY	652,195		652,195		652,195
50	PHYSICAL THERAPY	714,573		714,573		714,573
51	OCCUPATIONAL THERAPY	42,877		42,877		42,877
52	SPEECH PATHOLOGY	23,856		23,856		23,856
53	ELECTROCARDIOLOGY	691,797		691,797		691,797
55	MEDICAL SUPPLIES CHARGED	2,372,450		2,372,450		2,372,450
56	DRUGS CHARGED TO PATIENTS	2,141,960		2,141,960		2,141,960
61	OUTPAT SERVICE COST CNTRS EMERGENCY	2,676,652		2,676,652		2,676,652
62	OBSERVATION BEDS (NON-DIS)	1,122,797		1,122,797		1,122,797
63	OTHER OUTPATIENT SERVICE OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	2,751,087		2,751,087		2,751,087
101	SUBTOTAL	32,463,292		32,463,292		32,463,292
102	LESS OBSERVATION BEDS	1,122,797		1,122,797		1,122,797
103	TOTAL	31,340,495		31,340,495		31,340,495

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET C
 I I TO 12/31/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	4,728,120		4,728,120			
26	INTENSIVE CARE UNIT	729,123		729,123			
33	NURSERY	442,785		442,785			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,716,738	5,689,836	7,406,574	.507831	.507831	.507831
40	ANESTHESIOLOGY	113,658	302,200	415,858	.601571	.601571	.601571
41	RADIOLOGY-DIAGNOSTIC	2,598,451	21,333,116	23,931,567	.143000	.143000	.143000
44	LABORATORY	2,000,811	7,804,304	9,805,115	.281949	.281949	.281949
49	RESPIRATORY THERAPY	1,864,528	336,325	2,200,853	.296337	.296337	.296337
50	PHYSICAL THERAPY	286,063	1,404,235	1,690,298	.422750	.422750	.422750
51	OCCUPATIONAL THERAPY	9,955	128,270	138,225	.310197	.310197	.310197
52	SPEECH PATHOLOGY	12,496	36,347	48,843	.488422	.488422	.488422
53	ELECTROCARDIOLOGY	419,880	2,112,823	2,532,703	.273146	.273146	.273146
55	MEDICAL SUPPLIES CHARGED	1,754,320	1,926,005	3,680,325	.644631	.644631	.644631
56	DRUGS CHARGED TO PATIENTS	2,374,063	2,635,941	5,010,004	.427537	.427537	.427537
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	288,783	6,199,195	6,487,978	.412556	.412556	.412556
62	OBSERVATION BEDS (NON-DIS	69,093	820,221	889,314	1.262543	1.262543	1.262543
63	OTHER OUTPATIENT SERVICE						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		4,016,506	4,016,506	.684945	.684945	.684945
101	SUBTOTAL	19,408,867	54,745,324	74,154,191			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,408,867	54,745,324	74,154,191			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
I 15-1331 I FROM 1/ 1/2008 I WORKSHEET C
I I TO 12/31/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	7,319,449		7,319,449		7,319,449
26	INTENSIVE CARE UNIT	1,586,291		1,586,291		1,586,291
33	NURSERY	169,087		169,087		169,087
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	3,761,289		3,761,289		3,761,289
40	ANESTHESIOLOGY	250,168		250,168		250,168
41	RADIOLOGY-DIAGNOSTIC	3,422,224		3,422,224		3,422,224
44	LABORATORY	2,764,540		2,764,540		2,764,540
49	RESPIRATORY THERAPY	652,195		652,195		652,195
50	PHYSICAL THERAPY	714,573		714,573		714,573
51	OCCUPATIONAL THERAPY	42,877		42,877		42,877
52	SPEECH PATHOLOGY	23,856		23,856		23,856
53	ELECTROCARDIOLOGY	691,797		691,797		691,797
55	MEDICAL SUPPLIES CHARGED	2,372,450		2,372,450		2,372,450
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	2,141,960		2,141,960		2,141,960
61	EMERGENCY	2,676,652		2,676,652		2,676,652
62	OBSERVATION BEDS (NON-DIS)	1,122,797		1,122,797		1,122,797
63	OTHER OUTPATIENT SERVICE OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	2,751,087		2,751,087		2,751,087
101	SUBTOTAL	32,463,292		32,463,292		32,463,292
102	LESS OBSERVATION BEDS	1,122,797		1,122,797		1,122,797
103	TOTAL	31,340,495		31,340,495		31,340,495

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
I 15-1331 I FROM 1/ 1/2008 I WORKSHEET C
I I TO 12/31/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	4,728,120		4,728,120			
26	INTENSIVE CARE UNIT	729,123		729,123			
33	NURSERY	442,785		442,785			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,716,738	5,689,836	7,406,574	.507831	.507831	.507831
40	ANESTHESIOLOGY	113,658	302,200	415,858	.601571	.601571	.601571
41	RADIOLOGY-DIAGNOSTIC	2,598,451	21,333,116	23,931,567	.143000	.143000	.143000
44	LABORATORY	2,000,811	7,804,304	9,805,115	.281949	.281949	.281949
49	RESPIRATORY THERAPY	1,864,528	336,325	2,200,853	.296337	.296337	.296337
50	PHYSICAL THERAPY	286,063	1,404,235	1,690,298	.422750	.422750	.422750
51	OCCUPATIONAL THERAPY	9,955	128,270	138,225	.310197	.310197	.310197
52	SPEECH PATHOLOGY	12,496	36,347	48,843	.488422	.488422	.488422
53	ELECTROCARDIOLOGY	419,880	2,112,823	2,532,703	.273146	.273146	.273146
55	MEDICAL SUPPLIES CHARGED	1,754,320	1,926,005	3,680,325	.644631	.644631	.644631
56	DRUGS CHARGED TO PATIENTS	2,374,063	2,635,941	5,010,004	.427537	.427537	.427537
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	288,783	6,199,195	6,487,978	.412556	.412556	.412556
62	OBSERVATION BEDS (NON-DIS	69,093	820,221	889,314	1.262543	1.262543	1.262543
63	OTHER OUTPATIENT SERVICE						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		4,016,506	4,016,506	.684945	.684945	.684945
101	SUBTOTAL	19,408,867	54,745,324	74,154,191			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,408,867	54,745,324	74,154,191			

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	3,761,289	873,251	2,888,038			3,761,289
40	ANESTHESIOLOGY	250,168	7,361	242,807			250,168
41	RADIOLOGY-DIAGNOSTIC	3,422,224	572,640	2,849,584			3,422,224
44	LABORATORY	2,764,540	309,168	2,455,372			2,764,540
49	RESPIRATORY THERAPY	652,195	69,339	582,856			652,195
50	PHYSICAL THERAPY	714,573	191,357	523,216			714,573
51	OCCUPATIONAL THERAPY	42,877	1,162	41,715			42,877
52	SPEECH PATHOLOGY	23,856	586	23,270			23,856
53	ELECTROCARDIOLOGY	691,797	105,679	586,118			691,797
55	MEDICAL SUPPLIES CHARGED	2,372,450	269,549	2,102,901			2,372,450
56	DRUGS CHARGED TO PATIENTS	2,141,960	114,453	2,027,507			2,141,960
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,676,652	386,741	2,289,911			2,676,652
62	OBSERVATION BEDS (NON-DIS	1,122,797		1,122,797			1,122,797
63	OTHER OUTPATIENT SERVICE						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	2,751,087	109,717	2,641,370			2,751,087
101	SUBTOTAL	23,388,465	3,011,003	20,377,462			23,388,465
102	LESS OBSERVATION BEDS	1,122,797		1,122,797			1,122,797
103	TOTAL	22,265,668	3,011,003	19,254,665			22,265,668

WKST A NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	7,406,574	.507831	.507831
40	ANESTHESIOLOGY	415,858	.601571	.601571
41	RADIOLOGY-DIAGNOSTIC	23,931,567	.143000	.143000
44	LABORATORY	9,805,115	.281949	.281949
49	RESPIRATORY THERAPY	2,200,853	.296337	.296337
50	PHYSICAL THERAPY	1,690,298	.422750	.422750
51	OCCUPATIONAL THERAPY	138,225	.310197	.310197
52	SPEECH PATHOLOGY	48,843	.488422	.488422
53	ELECTROCARDIOLOGY	2,532,703	.273146	.273146
55	MEDICAL SUPPLIES CHARGED	3,680,325	.644631	.644631
56	DRUGS CHARGED TO PATIENTS	5,010,004	.427537	.427537
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	6,487,978	.412556	.412556
62	OBSERVATION BEDS (NON-DIS	889,314	1.262543	1.262543
63	OTHER OUTPATIENT SERVICE			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	4,016,506	.684945	.684945
101	SUBTOTAL	68,254,163		
102	LESS OBSERVATION BEDS	889,314		
103	TOTAL	67,364,849		

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	CAPITAL COST WKST B PT II & III, COL. 27	OPERATING COST NET OF CAPITAL COST	CAPITAL REDUCTION	OPERATING COST REDUCTION AMOUNT	COST NET OF CAP AND OPER COST REDUCTION
		1	2	3	4	5	6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	3,761,289	873,251	2,888,038			3,761,289
40	ANESTHESIOLOGY	250,168	7,361	242,807			250,168
41	RADIOLOGY-DIAGNOSTIC	3,422,224	572,640	2,849,584			3,422,224
44	LABORATORY	2,764,540	309,168	2,455,372			2,764,540
49	RESPIRATORY THERAPY	652,195	69,339	582,856			652,195
50	PHYSICAL THERAPY	714,573	191,357	523,216			714,573
51	OCCUPATIONAL THERAPY	42,877	1,162	41,715			42,877
52	SPEECH PATHOLOGY	23,856	586	23,270			23,856
53	ELECTROCARDIOLOGY	691,797	105,679	586,118			691,797
55	MEDICAL SUPPLIES CHARGED	2,372,450	269,549	2,102,901			2,372,450
56	DRUGS CHARGED TO PATIENTS	2,141,960	114,453	2,027,507			2,141,960
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,676,652	386,741	2,289,911			2,676,652
62	OBSERVATION BEDS (NON-DIS	1,122,797		1,122,797			1,122,797
63	OTHER OUTPATIENT SERVICE						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	2,751,087	109,717	2,641,370			2,751,087
101	SUBTOTAL	23,388,465	3,011,003	20,377,462			23,388,465
102	LESS OBSERVATION BEDS	1,122,797		1,122,797			1,122,797
103	TOTAL	22,265,668	3,011,003	19,254,665			22,265,668

WKST A NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	7,406,574	.507831	.507831
40	ANESTHESIOLOGY	415,858	.601571	.601571
41	RADIOLOGY-DIAGNOSTIC	23,931,567	.143000	.143000
44	LABORATORY	9,805,115	.281949	.281949
49	RESPIRATORY THERAPY	2,200,853	.296337	.296337
50	PHYSICAL THERAPY	1,690,298	.422750	.422750
51	OCCUPATIONAL THERAPY	138,225	.310197	.310197
52	SPEECH PATHOLOGY	48,843	.488422	.488422
53	ELECTROCARDIOLOGY	2,532,703	.273146	.273146
55	MEDICAL SUPPLIES CHARGED	3,680,325	.644631	.644631
56	DRUGS CHARGED TO PATIENTS	5,010,004	.427537	.427537
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	6,487,978	.412556	.412556
62	OBSERVATION BEDS (NON-DIS	889,314	1.262543	1.262543
63	OTHER OUTPATIENT SERVICE			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	4,016,506	.684945	.684945
101	SUBTOTAL	68,254,163		
102	LESS OBSERVATION BEDS	889,314		
103	TOTAL	67,364,849		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS
 PROVIDER NO: 15-1331 PERIOD: FROM 1/1/2008 TO 12/31/2008
 COMPONENT NO: 15-1331
 PREPARED 5/15/2009
 WORKSHEET D
 PART V

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge	Cost/Charge	Cost/Charge	Outpatient	Outpatient
	Ratio (C, Pt I, col. 9)	Ratio (C, Pt I, col. 9)	Ratio (C, Pt II, col. 9)	Ambulatory Surgical Ctr	Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.507831		.507831		
40 ANESTHESIOLOGY	.601571		.601571		
41 RADIOLOGY-DIAGNOSTIC	.143000		.143000		
44 LABORATORY	.281949		.281949		
49 RESPIRATORY THERAPY	.296337		.296337		
50 PHYSICAL THERAPY	.422750		.422750		
51 OCCUPATIONAL THERAPY	.310197		.310197		
52 SPEECH PATHOLOGY	.488422		.488422		
53 ELECTROCARDIOLOGY	.273146		.273146		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.644631		.644631		
56 DRUGS CHARGED TO PATIENTS	.427537		.427537		
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY	.412556		.412556		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.262543		1.262543		
63 OTHER OUTPATIENT SERVICE COST CENTER					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.684945		.684945		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		2,070,356			
40 ANESTHESIOLOGY		56,081			
41 RADIOLOGY-DIAGNOSTIC		6,552,922			
44 LABORATORY		2,039,902			
49 RESPIRATORY THERAPY		66,623			
50 PHYSICAL THERAPY		467,587			
51 OCCUPATIONAL THERAPY		35,574			
52 SPEECH PATHOLOGY		8,376			
53 ELECTROCARDIOLOGY		1,117,427			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		744,593			
56 DRUGS CHARGED TO PATIENTS		1,606,733			
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY		1,198,172			
62 OBSERVATION BEDS (NON-DISTINCT PART)		361,250			
63 OTHER OUTPATIENT SERVICE COST CENTER					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		16,325,596			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		16,325,596			

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART V
 I 15-1331 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	All Other		Hospital I/P	Hospital I/P
	9	10	Part B Charges	Part B Costs
(A) ANCILLARY SRVC COST CNTRS				
37 OPERATING ROOM		1,051,391		
40 ANESTHESIOLOGY		33,737		
41 RADIOLOGY-DIAGNOSTIC		937,068		
44 LABORATORY		575,148		
49 RESPIRATORY THERAPY		19,743		
50 PHYSICAL THERAPY		197,672		
51 OCCUPATIONAL THERAPY		11,035		
52 SPEECH PATHOLOGY		4,091		
53 ELECTROCARDIOLOGY		305,221		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		479,988		
56 DRUGS CHARGED TO PATIENTS		686,938		
OUTPAT SERVICE COST CNTRS				
61 EMERGENCY		494,313		
62 OBSERVATION BEDS (NON-DISTINCT PART)		456,094		
63 OTHER OUTPATIENT SERVICE COST CENTER				
OTHER REIMBURS COST CNTRS				
65 AMBULANCE SERVICES				
101 SUBTOTAL		5,252,439		
102 CRNA CHARGES				
103 LESS PBP CLINIC LAB SVCS-				
PROGRAM ONLY CHARGES				
104 NET CHARGES		5,252,439		

(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 5/15/2009
I 15-1331	I FROM 1/ 1/2008	I WORKSHEET D
I COMPONENT NO:	I TO 12/31/2008	I PART VI
I 15-1331	I	I

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.427537
2	PROGRAM VACCINE CHARGES		8,413
3	PROGRAM COSTS		3,597

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART V
 I 15-1331 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.507831				409,952
40 ANESTHESIOLOGY	.601571				40,110
41 RADIOLOGY-DIAGNOSTIC	.143000				2,087,553
44 LABORATORY	.281949				826,801
49 RESPIRATORY THERAPY	.296337				37,106
50 PHYSICAL THERAPY	.422750				185,165
51 OCCUPATIONAL THERAPY	.310197				21,745
52 SPEECH PATHOLOGY	.488422				3,230
53 ELECTROCARDIOLOGY	.273146				140,671
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.644631				225,874
56 DRUGS CHARGED TO PATIENTS	.427537				400,013
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY	.412556				1,029,167
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.262543				185,510
63 OTHER OUTPATIENT SERVICE COST CENTER					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.684945				548,705
101 SUBTOTAL					6,141,602
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					6,141,602

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO: 15-1331
PERIOD: FROM 1/1/2008 TO 12/31/2008
COMPONENT NO: 15-1331
PREPARED 5/15/2009
WORKSHEET D
PART V

TITLE XIX - O/P

HOSPITAL

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

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART V
 I 15-1331 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
(A) ANCILLARY SRVC COST CNTRS	8	9	9.01	9.02	9.03
37 OPERATING ROOM		208,186			
40 ANESTHESIOLOGY		24,129			
41 RADIOLOGY-DIAGNOSTIC		298,520			
44 LABORATORY		233,116			
49 RESPIRATORY THERAPY		10,996			
50 PHYSICAL THERAPY		78,279			
51 OCCUPATIONAL THERAPY		6,745			
52 SPEECH PATHOLOGY		1,578			
53 ELECTROCARDIOLOGY		38,424			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		145,605			
56 DRUGS CHARGED TO PATIENTS		171,020			
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY		424,589			
62 OBSERVATION BEDS (NON-DISTINCT PART)		234,214			
63 OTHER OUTPATIENT SERVICE COST CENTER					
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES		375,833			
101 SUBTOTAL		2,251,234			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		2,251,234			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,678
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,678
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,678
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,874
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	7,319,449
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7,319,449

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,711,429
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,711,429
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.972138
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	653.65
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	7,319,449

COMPUTATION OF INPATIENT OPERATING COST

TITLE XVIII PART A

HOSPITAL

OTHER

II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,289.09
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,704,845
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,704,845

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	1,586,291	461	3,440.98	289	994,443
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1 2,894,440
49 TOTAL PROGRAM INPATIENT COSTS					7,593,728

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
 52 TOTAL PROGRAM EXCLUDABLE COST
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN
 ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES
 55 TARGET AMOUNT PER DISCHARGE
 56 TARGET AMOUNT
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
 58 BONUS PAYMENT
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED
 AND COMPOUNDED BY THE MARKET BASKET
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET
 BASKET
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE
 LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN
 EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)
 OTHERWISE ENTER ZERO.
 58.04 RELIEF PAYMENT
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1
 59.03 PROGRAM DISCHARGES AFTER JULY 1
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2008 I PART III
 I 15-1331 I I

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	871
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,289.09
85	OBSERVATION BED COST	1,122,797

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,678
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,678
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,678
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	183
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	413
16	NURSERY DAYS (TITLE V OR XIX ONLY)	236

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	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	7,319,449
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	7,319,449

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,711,429
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,711,429
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.972138
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	653.65
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	7,319,449

TITLE XIX - I/P HOSPITAL OTHER
 PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,289.09
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 235,903
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 235,903

	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST
	1	2	3	4	5
42 NURSERY (TITLE V & XIX ONLY)	169,087	413	409.41	236	96,621
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	1,586,291	461	3,440.98	63	216,782
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1 558,386
49 TOTAL PROGRAM INPATIENT COSTS					1,107,692

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
 52 TOTAL PROGRAM EXCLUDABLE COST
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN
 ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES
 55 TARGET AMOUNT PER DISCHARGE
 56 TARGET AMOUNT
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
 58 BONUS PAYMENT
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED
 AND COMPOUNDED BY THE MARKET BASKET
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET
 BASKET
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE
 LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN
 EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)
 OTHERWISE ENTER ZERO.
 58.04 RELIEF PAYMENT
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1
 59.03 PROGRAM DISCHARGES AFTER JULY 1
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

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

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2008 I PART III
 I 15-1331 I I

COMPUTATION OF INPATIENT OPERATING COST

TITLE XIX - I/P

HOSPITAL

OTHER

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

66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST
 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

1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BED DAYS 871
 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,289.09
 85 OBSERVATION BED COST 1,122,797

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-1331 I I

TITLE XVIII, PART A

HOSPITAL

OTHER

WKST A NO.	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT
		TO CHARGES	CHARGES	COST
		1	2	3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		2,334,679	
26	INTENSIVE CARE UNIT		434,331	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.507831	698,615	354,778
40	ANESTHESIOLOGY	.601571	44,309	26,655
41	RADIOLOGY-DIAGNOSTIC	.143000	1,164,796	166,566
44	LABORATORY	.281949	1,107,035	312,127
49	RESPIRATORY THERAPY	.296337	481,694	142,744
50	PHYSICAL THERAPY	.422750	223,672	94,557
51	OCCUPATIONAL THERAPY	.310197	8,705	2,700
52	SPEECH PATHOLOGY	.488422	11,028	5,386
53	ELECTROCARDIOLOGY	.273146	397,112	108,470
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.644631	1,545,267	996,127
56	DRUGS CHARGED TO PATIENTS	.427537	1,589,574	679,602
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.412556	11,461	4,728
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.262543		
63	OTHER OUTPATIENT SERVICE COST CENTER			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		7,283,268	2,894,440
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		7,283,268	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-1331 I

TITLE XIX

HOSPITAL

OTHER

WKST A NO.	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT
		TO CHARGES	CHARGES	COST
		1	2	3
25	INPAT ROUTINE SRVC CNTRS			
	ADULTS & PEDIATRICS		1,079,907	
26	INTENSIVE CARE UNIT		108,914	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.507831	255,537	129,770
40	ANESTHESIOLOGY	.601571	9,615	5,784
41	RADIOLOGY-DIAGNOSTIC	.143000	200,403	28,658
44	LABORATORY	.281949	254,009	71,618
49	RESPIRATORY THERAPY	.296337	164,664	48,796
50	PHYSICAL THERAPY	.422750	10,861	4,591
51	OCCUPATIONAL THERAPY	.310197		
52	SPEECH PATHOLOGY	.488422		
53	ELECTROCARDIOLOGY	.273146	22,768	6,219
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.644631	209,053	134,762
56	DRUGS CHARGED TO PATIENTS	.427537	242,664	103,748
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.412556	59,240	24,440
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.262543		
63	OTHER OUTPATIENT SERVICE COST CENTER			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		1,428,814	558,386
102	LESS PBP CLINIC LABORATORY SERVICES -			
	PROGRAM ONLY CHARGES			
103	NET CHARGES		1,428,814	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET E
 I COMPONENT NO: I TO 12/31/2008 I PART B
 I 15-1331 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 5,256,036
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1,
 2001 (SEE INSTRUCTIONS).
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.
 1.04 LINE 1.01 TIMES LINE 1.03.
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)
 1.07 ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9,
 9.01, 9.02) LINE 101.
 2 INTERNS AND RESIDENTS
 3 ORGAN ACQUISITIONS
 4 COST OF TEACHING PHYSICIANS
 5 TOTAL COST (SEE INSTRUCTIONS) 5,256,036

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES
 6 ANCILLARY SERVICE CHARGES
 7 INTERNS AND RESIDENTS SERVICE CHARGES
 8 ORGAN ACQUISITION CHARGES
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.
 10 TOTAL REASONABLE CHARGES
 CUSTOMARY CHARGES
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR
 PAYMENT FOR SERVICES ON A CHARGE BASIS
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE
 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT
 BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).
 13 RATIO OF LINE 11 TO LINE 12
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 5,308,596
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 44,870
 18.01 CAH ACTUAL BILLED COINSURANCE 2,915,008
 LINE 17.01 (SEE INSTRUCTIONS)
 19 SUBTOTAL (SEE INSTRUCTIONS) 2,348,718
 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)
 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
 22 ESRD DIRECT MEDICAL EDUCATION COSTS
 23 SUBTOTAL 2,348,718
 24 PRIMARY PAYER PAYMENTS 437
 25 SUBTOTAL 2,348,281
 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)
 26 COMPOSITE RATE ESRD
 27 BAD DEBTS (SEE INSTRUCTIONS) 329,025
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 329,025
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 306,719
 28 SUBTOTAL 2,677,306
 29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER
 TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.
 30 OTHER ADJUSTMENTS (SPECIFY)
 30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)
 31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING
 FROM DISPOSITION OF DEPRECIABLE ASSETS.
 32 SUBTOTAL 2,677,306
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
 34 INTERIM PAYMENTS 1,229,827
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
 35 BALANCE DUE PROVIDER/PROGRAM 1,447,479
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-1331 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,796,920		1,271,243
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01	8/15/2008	217,822		
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50			8/15/2008	41,416
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL		217,822		-41,416
4 TOTAL INTERIM PAYMENTS		5,014,742		1,229,827
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT		2,083,133		1,447,479
AMOUNT (BALANCE DUE)				
BASED ON COST REPORT (1)				
TOTAL MEDICARE PROGRAM LIABILITY		7,097,875		2,677,306

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

I PROVIDER NO:	I PERIOD:	I PREPARED 5/15/2009
I 15-1331	I FROM 1/ 1/2008	I WORKSHEET E-3
I COMPONENT NO:	I TO 12/31/2008	I PART II
I 15-1331	I	I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	7,593,728
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	7,593,728
5	PRIMARY PAYER PAYMENTS	25,927
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	7,643,479

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	7,643,479
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	640,202
21	EXCESS REASONABLE COST	
22	SUBTOTAL	7,003,277
23	COINSURANCE	768
24	SUBTOTAL	7,002,509
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	95,366
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	95,366
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	88,575
26	SUBTOTAL	7,097,875
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	7,097,875
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	5,014,742
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	2,083,133
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	15,548,756			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	10,657,997			
5	OTHER RECEIVABLES	3,835,001			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-5,801,416			
7	INVENTORY	761,804			
8	PREPAID EXPENSES	757,023			
9	OTHER CURRENT ASSETS	4,007,903			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	29,767,068			
FIXED ASSETS					
12	LAND	3,195,260			
12.01	LAND IMPROVEMENTS	3,441,104			
13	LESS ACCUMULATED DEPRECIATION	-464,246			
14	BUILDINGS	36,296,574			
14.01	LESS ACCUMULATED DEPRECIATION	-2,239,123			
15	LEASEHOLD IMPROVEMENTS	109,272			
15.01	LESS ACCUMULATED DEPRECIATION	-61,109			
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	16,839,739			
18.01	LESS ACCUMULATED DEPRECIATION	-7,211,655			
19	MINOR EQUIPMENT DEPRECIABLE	976,505			
19.01	LESS ACCUMULATED DEPRECIATION	-397,968			
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	50,484,353			
OTHER ASSETS					
22	INVESTMENTS	1,766,108			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS	1,766,108			
27	TOTAL ASSETS	82,017,529			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	2,652,790			
29 SALARIES, WAGES & FEES PAYABLE	1,346,486			
30 PAYROLL TAXES PAYABLE	42,842			
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES				
36 TOTAL CURRENT LIABILITIES	4,042,118			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	29,654,754			
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	29,654,754			
43 TOTAL LIABILITIES	33,696,872			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	48,320,657			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	48,320,657			
52 TOTAL LIABILITIES AND FUND BALANCES	82,017,529			

STATEMENT OF CHANGES IN FUND BALANCES

GENERAL FUND SPECIFIC PURPOSE FUND

1 2 3 4

1	FUND BALANCE AT BEGINNING	52,850,397
	OF PERIOD	
2	NET INCOME (LOSS)	-4,532,540
3	TOTAL	48,317,857
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)	
	ADDITIONS (CREDIT ADJUSTM	2,800
5		
6		
7		
8		
9		
10	TOTAL ADDITIONS	2,800
11	SUBTOTAL	48,320,657
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)	
13	DEDUCTIONS (DEBIT ADJUSTM	
14		
15		
16		
17		
18	TOTAL DEDUCTIONS	
19	FUND BALANCE AT END OF	48,320,657
	PERIOD PER BALANCE SHEET	

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)	
	ADDITIONS (CREDIT ADJUSTM	
5		
6		
7		
8		
9		
10	TOTAL ADDITIONS	
11	SUBTOTAL	
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)	
13	DEDUCTIONS (DEBIT ADJUSTM	
14		
15		
16		
17		
18	TOTAL DEDUCTIONS	
19	FUND BALANCE AT END OF	
	PERIOD PER BALANCE SHEET	

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET G-2
 I I TO 12/31/2008 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	5,236,489		5,236,489
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	5,236,489		5,236,489
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	733,791		733,791
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	733,791		733,791
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	5,970,280		5,970,280
17 00 ANCILLARY SERVICES	13,150,964	43,709,401	56,860,365
18 00 OUTPATIENT SERVICES	357,876	7,019,415	7,377,291
19 00 HOME HEALTH AGENCY		716,413	716,413
20 00 AMBULANCE SERVICES		4,016,506	4,016,506
24 00 PHYS PRO FEES AND PHYS OFC		9,376,841	9,376,841
25 00 TOTAL PATIENT REVENUES	19,479,120	64,838,576	84,317,696

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		42,177,623	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 AJE #1	30,737		
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS		30,737	
40 00 TOTAL OPERATING EXPENSES		42,146,886	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET G-3
 I I TO 12/31/2008 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	84,317,696
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	44,527,621
3	NET PATIENT REVENUES	39,790,075
4	LESS: TOTAL OPERATING EXPENSES	42,146,886
5	NET INCOME FROM SERVICE TO PATIENTS	-2,356,811
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	780,257
7	INCOME FROM INVESTMENTS	644,962
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	111,723
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	2,909
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	10,685
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	266,087
23	GOVERNMENTAL APPROPRIATIONS	
24	DIETARY REVENUE	3,876
24.01	OTHER MISC REVENUE	37
25	TOTAL OTHER INCOME	1,820,536
26	TOTAL	-536,275
	OTHER EXPENSES	
27	EXTRAORD ITEMS PROP AND PLANT	3,286,404
28	ESTRAORD ITEMS LOSS ON IMPARED EQUIP	709,861
29		
30	TOTAL OTHER EXPENSES	3,996,265
31	NET INCOME (OR LOSS) FOR THE PERIOD	-4,532,540

HHA 1

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPORTATION 3	CONTRACTED/ PURCHASED SVCS 4	OTHER COSTS 5	TOTAL 6
GENERAL SERVICE COST CENTERS						
1						
2						
3						
4			30,544			30,544
5	99,030				37,142	136,172
HHA REIMBURSABLE SERVICES						
6	120,497					120,497
7	56,427			35,199		91,626
8				9,580		9,580
9						
10						
11	37,247					37,247
12					7,722	7,722
13						
13.20						
14						
HHA NONREIMBURSABLE SERVICES						
15						
16						
17						
18						
19						
20						
21						
22						
23						
23.50						
24	313,201		30,544	44,779	44,864	433,388

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10
GENERAL SERVICE COST CENTERS				
1				
2				
3				
4		30,544		30,544
5	-7,350	128,822		128,822
HHA REIMBURSABLE SERVICES				
6		120,497		120,497
7		91,626		91,626
8		9,580		9,580
9				
10				
11		37,247		37,247
12		7,722		7,722
13				
13.20				
14				
HHA NONREIMBURSABLE SERVICES				
15				
16				
17				
18				
19				
20				
21				
22				
23				
23.50				
24	-7,350	426,038		426,038

HHA 1

	NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
	0	1	2	3	4	4A	5
GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5	30,544					30,544	
	128,822						128,822
HHA REIMBURSABLE SERVICES							
6	120,497					120,497	58,491
7	91,626					91,626	43,255
8	9,580					9,580	4,509
9							
10							
11	37,247					37,247	19,220
12	7,722					7,722	3,347
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	426,038				30,544	426,038	

TOTAL

6

GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5							
HHA REIMBURSABLE SERVICES							
6	193,438					193,438	
7	143,053					143,053	
8	14,913					14,913	
9							
10							
11	63,565					63,565	
12	11,069					11,069	
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	426,038					426,038	

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET H-4
 I HHA NO: I TO 12/31/2008 I PART II
 I 15-7242 I

HHA 1

	CAP-REL COST-BLDG & FIX (SQUARE FEET)	CAP-REL COST-MOV EQUIP (DOLLAR VALUE)	PLANT OPER & MAINT (SQUARE FEET)	TRANSPORTATIO N (MILEAGE)	RECONCILIATIO N (ADMINISTRATIV E & GENERAL (ACCUM. COST)
	1	2	3	4	5A	5
GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX					
2	CAP-REL COST-MOV EQUIP					
3	PLANT OPER & MAINT					
4	TRANSPORTATION					
5	ADMINISTRATIVE & GENERAL					
				65,337	-128,822	297,216
HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE					
7	PHYSICAL THERAPY					
8	OCCUPATIONAL THERAPY					
9	SPEECH PATHOLOGY					
10	MEDICAL SOCIAL SERVICES					
11	HOME HEALTH AIDE					
12	SUPPLIES					
13	DRUGS					
13.20	COST ADMINISTERING DRUGS					
14	DME					
HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS					
16	RESPIRATORY THERAPY					
17	PRIVATE DUTY NURSING					
18	CLINIC					
19	HEALTH PROM ACTIVITIES					
20	DAY CARE PROGRAM					
21	HOME DEL MEALS PROGRAM					
22	HOMEMAKER SERVICE					
23	ALL OTHERS					
23.50	TELEMEDICINE					
24	TOTAL (SUM OF LINES 1-23)					
				65,337	-128,822	297,216
25	COST TO BE ALLOCATED					
				30,544		128,822
26	UNIT COST MULTIPLIER					
				.467484		.433429

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1) 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE 4	EMPLOYEE BEN EFITS 5	SUBTOTAL 5A	ADMINISTRATI VE & GENERAL 6
1 ADMIN & GENERAL		31,304	29,266	23,792	84,362	14,331
2 SKILLED NURSING CARE	193,438			28,949	222,387	37,777
3 PHYSICAL THERAPY	143,053			13,556	156,609	26,603
4 OCCUPATIONAL THERAPY	14,913				14,913	2,533
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE	63,565			8,949	72,514	12,318
8 SUPPLIES	11,069				11,069	1,880
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	426,038	31,304	29,266	75,246	561,854	95,442
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	OPERATION OF PLANT 8	LAUNDRY & LI NEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMI NISTRATION 14
1 ADMIN & GENERAL	37,101		16,424			92,262
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	37,101		16,424			92,262
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	CENTRAL SERVICES & SUPPL 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	POST STEP DOWN ADJUST 26
1 ADMIN & GENERAL					244,480	
2 SKILLED NURSING CARE					260,164	
3 PHYSICAL THERAPY					183,212	
4 OCCUPATIONAL THERAPY					17,446	
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE					84,832	
8 SUPPLIES					12,949	
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)					803,083	
21 UNIT COST MULTIPLIER						

- (1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	SUBTOTAL 27	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29
1 ADMIN & GENERAL	244,480		
2 SKILLED NURSING CARE	260,164	113,865	374,029
3 PHYSICAL THERAPY	183,212	80,185	263,397
4 OCCUPATIONAL THERAPY	17,446	7,635	25,081
5 SPEECH PATHOLOGY			
6 MEDICAL SOCIAL SERVICES			
7 HOME HEALTH AIDE	84,832	37,128	121,960
8 SUPPLIES	12,949	5,667	18,616
9 DRUGS			
9.20 COST ADMINISTERING DRUGS			
10 DME			
11 HOME DIALYSIS AIDE SVCS			
12 RESPIRATORY THERAPY			
13 PRIVATE DUTY NURSING			
14 CLINIC			
15 HEALTH PROM ACTIVITIES			
16 DAY CARE PROGRAM			
17 HOME DEL MEALS PROGRAM			
18 HOMEMAKER SERVICE			
19 ALL OTHER			
19.50 TELEMEDICINE			
20 TOTAL (SUM OF 1-19) (2)	803,083	244,480	803,083
21 UNIT COST MULTIPLIER		0.437663	

- (1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	NEW CAP REL COSTS-BLDG & (SQUARE FEET) 3	NEW CAP REL COSTS-MVBLE (SQUARE FEET) 4	EMPLOYEE BEN EFITS (GROSS SALARIES) 5	RECONCILIATI ON 6A	ADMINISTRATI VE & GENERAL (ACCUM. COST) 6	OPERATION OF PLANT (SQUARE FEET) 8
1 ADMIN & GENERAL	1,435	1,435	99,030		84,362	1,435
2 SKILLED NURSING CARE			120,497		222,387	
3 PHYSICAL THERAPY			56,426		156,609	
4 OCCUPATIONAL THERAPY					14,913	
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE			37,247		72,514	
8 SUPPLIES					11,069	
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	1,435	1,435	313,200		561,854	1,435
21 COST TO BE ALLOCATED	31,304	29,266	75,246		95,442	37,101
22 UNIT COST MULTIPLIER	21.814634	20.394425	0.240249		0.169870	25.854355

HHA COST CENTER	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY) 9	HOUSEKEEPING (SQUARE FEET) 10	DIETARY (PATIENT) AYS 11	CAFETERIA D (HOURS OF S) ERVICE 12	NURSING ADMI NISTRATION (DIRECT) NRSGING HRS) 14	CENTRAL SERV ICES & SUPPL (COSTED) REQUIS.) 15
1 ADMIN & GENERAL		1,435			13,548	
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)		1,435			13,548	
21 COST TO BE ALLOCATED		16,424			92,262	
22 UNIT COST MULTIPLIER		11.445296			6.810009	

Health Financial Systems MCRIF32
 ALLOCATION OF GENERAL SERVICE
 COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

FOR HARRISON COUNTY HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET H-5
 I HHA NO: I TO 12/31/2008 I PART II
 I 15-7242 I

HHA 1

PHARMACY	MEDICAL RECO RDS & LIBRAR	SOCIAL SERVI CE
(COSTED)	(TIME)	(PATIENT D
REQUIS.)	SPENT)	AYS)
16	17	18

HHA COST CENTER

- 1 ADMIN & GENERAL
- 2 SKILLED NURSING CARE
- 3 PHYSICAL THERAPY
- 4 OCCUPATIONAL THERAPY
- 5 SPEECH PATHOLOGY
- 6 MEDICAL SOCIAL SERVICES
- 7 HOME HEALTH AIDE
- 8 SUPPLIES
- 9 DRUGS
- 9.20 COST ADMINISTERING DRUGS
- 10 DME
- 11 HOME DIALYSIS AIDE SVCS
- 12 RESPIRATORY THERAPY
- 13 PRIVATE DUTY NURSING
- 14 CLINIC
- 15 HEALTH PROM ACTIVITIES
- 16 DAY CARE PROGRAM
- 17 HOME DEL MEALS PROGRAM
- 18 HOMEMAKER SERVICE
- 19 ALL OTHER
- 19.50 TELEMEDICINE
- 20 TOTAL (SUM OF 1-19)
- 21 COST TO BE ALLOCATED
- 22 UNIT COST MULTIPLIER

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET H-6
 I HHA NO: I TO 12/31/2008 I PARTS I II & III
 I 15-7242 I I HHA 1

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
 COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

COST PER VISIT COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS PART A
1 SKILLED NURSING	2	374,029	2	374,029	4	179.74	6 403
2 PHYSICAL THERAPY	3	263,397		263,397	1,186	222.09	342
3 OCCUPATIONAL THERAPY	4	25,081		25,081	74	338.93	21
4 SPEECH PATHOLOGY	5						
5 MEDICAL SOCIAL SERVICES	6						
6 HOME HEALTH AIDE SERVICE	7	121,960		121,960	1,571	77.63	118
7 TOTAL		784,467		784,467	4,912		884

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	SUBJECT TO DEDUCT & COINSUR	
1 SKILLED NURSING	7	235	9	11	12
2 PHYSICAL THERAPY		252	72,435	42,239	114,674
3 OCCUPATIONAL THERAPY		26	75,955	55,967	131,922
4 SPEECH PATHOLOGY			7,118	8,812	15,930
5 MEDICAL SOCIAL SERVICES					
6 HOME HEALTH AIDE SERVICES		135	9,160	10,480	19,640
7 TOTAL		648	164,668	117,498	282,166

LIMITATION COST COMPUTATION

PATIENT SERVICES	1	2	3	4	PROGRAM COST LIMITS 5	PROGRAM VISITS PART A 6
8 SKILLED NURSING						
9 PHYSICAL THERAPY						
10 OCCUPATIONAL THERAPY						
11 SPEECH PATHOLOGY						
12 MEDICAL SOCIAL SERVICES						
13 HOME HEALTH AIDE SERVICE						
14 TOTAL						

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	SUBJECT TO DEDUCT & COINSUR	
8 SKILLED NURSING	7	8	9	11	12
9 PHYSICAL THERAPY					
10 OCCUPATIONAL THERAPY					
11 SPEECH PATHOLOGY					
12 MEDICAL SOCIAL SERVICES					
13 HOME HEALTH AIDE SERVICE					
14 TOTAL					

I PROVIDER NO: I PERIOD: I PREPARED 5/15/2009
 I 15-1331 I FROM 1/ 1/2008 I WORKSHEET H-6
 I HHA NO: I TO 12/31/2008 I PARTS I II & III
 I 15-7242 I I HHA 1

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:

COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

SUPPLIES AND EQUIPMENT COST COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	PROGRAM COVERED CHARGES PART A
		1	2	3	4	5	6
15 COST OF MEDICAL SUPPLIES	8.00	18,616		18,616	44,696	.416503	5,472
16 COST OF DRUGS	9.00						
16.20 COST OF DRUGS	9.20						

	PROGRAM COVERED CHARGES		COST OF SERVICES	
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR
	7	8	9	10
15 COST OF MEDICAL SUPPLIES	3,120		2,279	1,299
16 COST OF DRUGS				
16.20 COST OF DRUGS				

PER BENEFICIARY COST LIMITATION:	MSA NUMBER	AMOUNT
	1	2
162 PROGRAM UNDUP CENSUS FROM WRKST S-4		
17 PER BENE COST LIMITATION (FRM FI)		
18 PER BENE COST LIMITATION (LN 17*18)		

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

	FROM WKST C PT I, COL 9	COST TO CHARGE RATIO	TOTAL HHA CHARGES	HHA SHARED ANCILLARY COSTS	TRANSFER TO PART I AS INDICATED
		1	2	3	4
1 PHYSICAL THERAPY	50	.422750			COL 2, LN 2
2 OCCUPATIONAL THERAPY	51	.310197			COL 2, LN 3
3 SPEECH PATHOLOGY	52	.488422			COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55	.644631			COL 2, LN 15
5 DRUGS CHARGED TO PATIENTS	56	.427537			COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

	FROM PART I, COL 5	COST PER VISIT	PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE		PROGRAM COSTS		PROG VISITS ON OR AFTER
			PRIOR 1/1/1998	1/1/1998 TO 12/31/1998	PRIOR 1/1/1998	1/1/1998 TO 12/31/1998	
		2	1	3	4	5	
1 PHYSICAL THERAPY	1	222.09	2.01	3	3.01	4	5
2 OCCUPATIONAL THERAPY	2	338.93					
3 SPEECH PATHOLOGY	3						
4 TOTAL (SUM OF LINES 1-3)	4						

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

TITLE XVIII HHA 1

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES
 PART A

PART B NOT SUBJECT TO DED & COINS 2
 PART B SUBJECT TO DED & COINS 3

- 1 REASONABLE COST OF SERVICES
- 2 TOTAL CHARGES
- 3 CUSTOMARY CHARGES
- 4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
- 5 AMOUNT 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(B)
- 6 RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)
- 7 TOTAL CUSTOMARY CHARGES
- 8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST
- 9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
- 10 PRIMARY PAYOR AMOUNTS

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

PART A SERVICES 1
 PART B SERVICES 2

10	TOTAL REASONABLE COST		
10.01	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	159,952	111,897
10.02	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		
10.03	TOTAL PPS REIMBURSEMENT-LUPA EPISODES	1,406	1,575
10.04	TOTAL PPS REIMBURSEMENT-PEP EPISODES		
10.05	TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.06	TOTAL PPS REIMBURSEMENT-SCIC EPISODES		
10.07	TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		
10.08	TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISODES		
10.09	TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.10	TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISODES		
10.11	TOTAL OTHER PAYMENTS		
10.12	DME PAYMENTS		
10.13	OXYGEN PAYMENTS		
10.14	PROSTHETIC AND ORTHOTIC PAYMENTS		
11	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)		
12	SUBTOTAL	161,358	113,472
13	EXCESS REASONABLE COST		
14	SUBTOTAL	161,358	113,472
15	COINSURANCE BILLED TO PROGRAM PATIENTS		
16	NET COST	161,358	113,472
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL COSTS - CURRENT COST REPORTING PERIOD	161,358	113,472
19	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
20	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION		
21	OTHER ADJUSTMENTS (SPECIFY)		
22	SUBTOTAL	161,358	113,472
23	SEQUESTRATION ADJUSTMENT		
24	SUBTOTAL	161,358	113,472
25	INTERIM PAYMENTS	161,358	113,472
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE PROVIDER/PROGRAM		
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II SECTION 115.2		

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/15/2009
I	15-1331	I	FROM 1/ 1/2008	I	WORKSHEET H-8
I	HHA NO:	I	TO 12/31/2008	I	
I	15-7242	I		I	

TITLE XVIII HHA 1

DESCRIPTION	P A R T A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		161,358		113,472
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01			
ADJUSTMENTS TO PROVIDER	.02			
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROGRAM	.50			
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99			
4 TOTAL INTERIM PAYMENTS		NONE 161,358		NONE 113,472
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
SUBTOTAL	.99			
6 DETERMINED NET SETTLEMENT		NONE		NONE
AMOUNT (BALANCE DUE)	.01			
SETTLEMENT TO PROGRAM	.02			
BASED ON COST REPORT (1)				
TOTAL MEDICARE PROGRAM LIABILITY		161,358		113,472

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.