

WOODLAWN HOSPITAL
ROCHESTER, INDIANA

PROVIDER NUMBERS
15-1313, 15-Z313 AND 15-7104

HOSPITAL STATEMENT OF REIMBURSABLE COST
YEAR ENDED DECEMBER 31, 2008

CPAs / ADVISORS



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 5
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	15-1313	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:
			I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/28/2009 TIME 15:40

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:

WOODLAWN HOSPITAL 15-1313

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.

ECR ENCRYPTION INFORMATION
DATE: 5/28/2009 TIME 15:40

7Txv32N1lyzJY1T1aarcaANzTH7Rc0
4tu2Q0G24Urod4kDpjeUzmHXxofliz
k9tN0q5G.Y0amd40

PI ENCRYPTION INFORMATION
DATE: 5/28/2009 TIME 15:40

k4b:pu3LBnsfsAPUhkVqomarlVn5J0
rXcX00WuBKJNdmKbc7jawVVqc.V4Br
pqbh4pNclU0UJ8U8

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A 2	TITLE XVIII	B 3	TITLE XIX	4
1	HOSPITAL	0	388,583	-205,942	128,775	
3	SWING BED - SNF	0	-11,040	0	0	
7	HOSPITAL-BASED HHA	0	0	0	0	
100	TOTAL	0	377,543	-205,942	128,775	

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.

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AND SETTLEMENT SUMMARY	I		I	TO 12/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

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	TITLE V	A	TITLE XVIII	B	TITLE XIX
	1	2		3	4
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3	SWING BED - SNF	0	-11,040	0	0
7	HOSPITAL-BASED HHA	0	0	0	0
100	TOTAL	0	377,543	-205,942	128,775

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HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET S-2
 I I TO 12/31/2008 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 1400 EAST 9TH STREET P.O. BOX:
 1.01 CITY: ROCHESTER STATE: IN ZIP CODE: 46975- COUNTY: FULTON

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	XVIII	XIX
02.00	HOSPITAL	15-1313		1/ 1/1966	N	O	O
04.00	SWING BED - SNF	15-2313		10/23/2001	N	O	N
09.00	HOSPITAL-BASED HHA	15-7104		2/ 7/1984	N	P	N

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

18 TYPE OF CONTROL 1 8 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

- 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? 1 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). 1
- 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. 1 N N
- 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 1
- 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 1
- 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
- 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
- 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
- 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION 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? N
- 25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.
- 25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N
- 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
- 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
I 15-1313 I FROM 1/ 1/2008 I WORKSHEET S-2
I I TO 12/31/2008 I

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)
26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.
26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 10/23/2001
28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02
28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 1 2 3 4
0 0.0000 0.0000
28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY 0.00 0

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR) % 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%
28.20 0.00%

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N
30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) Y
30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 N
30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N
30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000). N
30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N
31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). 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 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N N
 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

TITLE XIX INPATIENT SERVICES

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

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND 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 Y

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

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? 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	N	N	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 N
 53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 0
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0

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

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

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

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

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?
ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW
FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST 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). / /

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
I 15-1313 I FROM 1/ 1/2008 I WORKSHEET S-3
I TO 12/31/2008 I PART I

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	I/P DAYS / TITLE V	O/P VISITS / TITLE XVIII	NOT LTCH N/A	TRIPS / TITLE XIX
1 ADULTS & PEDIATRICS	21	7,686	184,464.00	3	4	4.01	5
2 HMO					1,214		161
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF					122		
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	21	7,686	184,464.00		1,336		161
6 INTENSIVE CARE UNIT	4	1,464	35,136.00		135		
12 TOTAL	25	9,150	219,600.00		1,471		161
13 RPCH VISITS							
18 HOME HEALTH AGENCY					2,596		150
25 TOTAL	25						
26 OBSERVATION BED DAYS							283
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	/ TRIPS / TOTAL OBSERVATION BEDS ADMITTED	DISCHARGES / TITLE XVIII	INTERNS & RES. / TOTAL	FTES / LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			3,104				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			122				
4 ADULTS & PED-SB NF			54				
5 TOTAL ADULTS AND PEDS			3,280				
6 INTENSIVE CARE UNIT			231				
12 TOTAL			3,511				
13 RPCH VISITS							
18 HOME HEALTH AGENCY			4,387				
25 TOTAL							
26 OBSERVATION BED DAYS	3	280	1,339	23	1,316		
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	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					394	63	1,030
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
12 TOTAL		302.13			394	63	1,030
13 RPCH VISITS							
18 HOME HEALTH AGENCY		10.54					
25 TOTAL		312.67					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
I 15-1313 I FROM 1/ 1/2008 I WORKSHEET S-4
I HHA NO: I TO 12/31/2008 I
I 15-7104 I
COUNTY: FULTON

HOME HEALTH AGENCY STATISTICAL DATA

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		124.00		

	TOTAL 5
1 HOME HEALTH AIDE HOURS	0
2 UNDUPLICATED CENSUS COUNT	

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

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00

HHA NO. OF FTE EMPLOYEES (2080 HRS)

	STAFF 1	CONTRACT 2	TOTAL 3
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	2,080.00		2,080.00
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			
5 OTHER ADMINISTRATIVE PERSONEL	2,195.00		2,195.00
6 DIRECTING NURSING SERVICE	11,621.00		11,621.00
7 NURSING SUPERVISOR			
8 PHYSICAL THERAPY SERVICE	1,309.00		1,309.00
9 PHYSICAL THERAPY SUPERVISOR			
10 OCCUPATIONAL THERAPY SERVICE	150.00		150.00
11 OCCUPATIONAL THERAPY SUPERVISOR			
12 SPEECH PATHOLOGY SERVICE	116.00		116.00
13 SPEECH PATHOLOGY SUPERVISOR			
14 MEDICAL SOCIAL SERVICE			
15 MEDICAL SOCIAL SERVICE SUPERVISOR			
16 HOME HEALTH AIDE	6,035.00		6,035.00
17 HOME HEALTH AIDE SUPERVISOR			
18			

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?	1	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).	9915	

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

	WITHOUT OUTLIERS 1	FULL EPISODES WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4
21 SKILLED NURSING VISITS	1,085	46	15	22
22 SKILLED NURSING VISIT CHARGES	172,307	6,532	2,452	3,314
23 PHYSICAL THERAPY VISITS	530	9	2	2
24 PHYSICAL THERAPY VISIT CHARGES	79,489	1,354	301	301
25 OCCUPATIONAL THERAPY VISITS	63	0	0	0
26 OCCUPATIONAL THERAPY VISIT CHARGES	9,439	0	0	0
27 SPEECH PATHOLOGY VISITS	42	0	0	0
28 SPEECH PATHOLOGY VISIT CHARGES	6,288	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	724	13	2	12
32 HOME HEALTH AIDE VISIT CHARGES	46,595	781	143	778
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	2,444	68	19	36
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	314,118	8,667	2,896	4,393
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	3,937	35	23	94

HOSPITAL-BASED HOME HEALTH AGENCY
 STATISTICAL DATA
 HOME HEALTH AGENCY STATISTICAL DATA

IN LIEU OF FORM CMS-2552-96 S-4 (05/2008)
 I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET S-4
 I HHA NO: I TO 12/31/2008 I
 I 15-7104 I
 COUNTY: FULTON

HHA 1

PPS 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	1,168
22 SKILLED NURSING VISIT CHARGES	0	0	184,605
23 PHYSICAL THERAPY VISITS	0	0	543
24 PHYSICAL THERAPY VISIT CHARGES	0	0	81,445
25 OCCUPATIONAL THERAPY VISITS	0	0	63
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	0	9,439
27 SPEECH PATHOLOGY VISITS	0	0	42
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	6,288
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31 HOME HEALTH AIDE VISITS	0	0	751
32 HOME HEALTH AIDE VISIT CHARGES	0	0	48,297
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	0	2,567
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	330,074
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	4,089

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A
I I TO 12/31/2008 I

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		1,522,632	1,522,632	3,116	1,525,748
5	0500	EMPLOYEE BENEFITS	175,519	1,485,974	1,661,493	42,259	1,703,752
6	0600	ADMINISTRATIVE & GENERAL	1,650,869	1,727,218	3,378,087	591,708	3,969,795
8	0800	OPERATION OF PLANT	203,216	955,055	1,158,271	44,915	1,203,186
9	0900	LAUNDRY & LINEN SERVICE	10,022	93,963	103,985		103,985
10	1000	HOUSEKEEPING	184,096	122,749	306,845		306,845
11	1100	DIETARY	315,423	296,398	611,821	-373,319	238,502
12	1200	CAFETERIA				373,319	373,319
14	1400	NURSING ADMINISTRATION	173,300	61,082	234,382		234,382
15	1500	CENTRAL SERVICES & SUPPLY	26,523	54,178	80,701		80,701
16	1600	PHARMACY	348,366	2,160,080	2,508,446		2,508,446
17	1700	MEDICAL RECORDS & LIBRARY	384,149	187,791	571,940		571,940
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	2,219,647	739,123	2,958,770		2,958,770
26	2600	INTENSIVE CARE UNIT	319,002	153,116	472,118		472,118
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	582,113	1,686,495	2,268,608		2,268,608
38	3800	RECOVERY ROOM	262,564	77,647	340,211		340,211
40	4000	ANESTHESIOLOGY	158,643	1,073,924	1,232,567		1,232,567
41	4100	RADIOLOGY-DIAGNOSTIC	955,527	1,310,156	2,265,683		2,265,683
44	4400	LABORATORY	578,430	1,087,599	1,666,029		1,666,029
49	4900	RESPIRATORY THERAPY	550,101	217,157	767,258		767,258
50	5000	PHYSICAL THERAPY	585,143	275,875	861,018		861,018
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	5600	DRUGS CHARGED TO PATIENTS					
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY	1,103,048	1,571,059	2,674,107		2,674,107
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
		OTHER REIMBURS COST CNTRS					
66	6600	DURABLE MEDICAL EQUIP-RENTED	7,148	30,771	37,919		37,919
71	7100	HOME HEALTH AGENCY	392,450	175,254	567,704		567,704
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE					
95		SUBTOTALS	11,185,299	17,065,296	28,250,595	681,998	28,932,593
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
97	9700	RESEARCH					
98	9800	PHYSICIANS' PRIVATE OFFICES	4,199,418	1,485,291	5,684,709	-572,067	5,112,642
99	9900	NONPAID WORKERS					
100	7950	ADVERTISING	88,504	319,107	407,611	-109,931	297,680
101		TOTAL	15,473,221	18,869,694	34,342,915	-0-	34,342,915

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A
I I TO 12/31/2008 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	32,084	1,557,832
5	0500 EMPLOYEE BENEFITS		1,703,752
6	0600 ADMINISTRATIVE & GENERAL	-452,624	3,517,171
8	0800 OPERATION OF PLANT		1,203,186
9	0900 LAUNDRY & LINEN SERVICE		103,985
10	1000 HOUSEKEEPING		306,845
11	1100 DIETARY	-37,876	200,626
12	1200 CAFETERIA	-112,082	261,237
14	1400 NURSING ADMINISTRATION		234,382
15	1500 CENTRAL SERVICES & SUPPLY	-19,089	61,612
16	1600 PHARMACY	-440,968	2,067,478
17	1700 MEDICAL RECORDS & LIBRARY		571,940
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		2,958,770
26	2600 INTENSIVE CARE UNIT		472,118
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		2,268,608
38	3800 RECOVERY ROOM		340,211
40	4000 ANESTHESIOLOGY	-1,196,181	36,386
41	4100 RADIOLOGY-DIAGNOSTIC	-36,784	2,228,899
44	4400 LABORATORY		1,666,029
49	4900 RESPIRATORY THERAPY	-86,392	680,866
50	5000 PHYSICAL THERAPY	-7,500	853,518
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		
56	5600 DRUGS CHARGED TO PATIENTS		
	OUTPAT SERVICE COST CNTRS		
61	6100 EMERGENCY	-1,392,216	1,281,891
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
66	6600 DURABLE MEDICAL EQUIP-RENTED	-2,239	35,680
71	7100 HOME HEALTH AGENCY		567,704
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
95	9500 SUBTOTALS	-3,751,867	25,180,726
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
97	9700 RESEARCH		
98	9800 PHYSICIANS' PRIVATE OFFICES		5,112,642
99	9900 NONPAID WORKERS		
100	7950 ADVERTISING		297,680
101	TOTAL	-3,751,867	30,591,048

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I NOT A CMS WORKSHEET
 I I TO 12/31/2008 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
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	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
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	
	OTHER REIMBURS COST		
66	DURABLE MEDICAL EQUIP-RENTED	6600	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
100	ADVERTISING	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151313	FROM 1/1/2008	5/28/2009
	TO 12/31/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	INCREASE			
	CODE (1) COST CENTER	LINE NO	SALARY	OTHER
	1 2	3	4	5
1 CAFETERIA	A CAFETERIA	12	192,464	180,855
2 WORKMANS COMP	B EMPLOYEE BENEFITS	5		42,259
3 PHYSICIAN CLINICS	C NEW CAP REL COSTS-BLDG & FIXT	3		45,375
4	ADMINISTRATIVE & GENERAL	6		148,567
5	OPERATION OF PLANT	8		44,915
6 ADVERTISING	D ADMINISTRATIVE & GENERAL	6	23,869	86,062
7 ROCHESTER CLERICAL	E ADMINISTRATIVE & GENERAL	6	311,669	21,541
36 TOTAL RECLASSIFICATIONS			528,002	569,574

(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
151313	FROM 1/ 1/2008	5/28/2009
	TO 12/31/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		DECREASE			A-7 REF 10
	(1)	COST CENTER	LINE NO	SALARY	OTHER	
	1	6	7	8	9	
1 CAFETERIA	A	DIETARY	11	192,464	180,855	
2 WORKMANS COMP	B	NEW CAP REL COSTS-BLDG & FIXT	3		42,259	12
3 PHYSICIAN CLINICS	C	PHYSICIANS' PRIVATE OFFICES	98		238,857	11
4						
5						
6 ADVERTISING	D	ADVERTISING	100	23,869	86,062	11
7 ROCHESTER CLERICAL	E	PHYSICIANS' PRIVATE OFFICES	98	311,669	21,541	
36 TOTAL RECLASSIFICATIONS				528,002	569,574	

(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
151313	1/ 1/2008	5/28/2009
	FROM	WORKSHEET A-6
	TO	12/31/2008
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : CAFETERIA

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	373,319
TOTAL RECLASSIFICATIONS FOR CODE A			373,319

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
DIETARY	11	373,319	
		373,319	

RECLASS CODE: B
EXPLANATION : WORKMANS COMP

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	EMPLOYEE BENEFITS	5	42,259
TOTAL RECLASSIFICATIONS FOR CODE B			42,259

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
NEW CAP REL COSTS-BLDG & FIXT	3	42,259	
		42,259	

RECLASS CODE: C
EXPLANATION : PHYSICIAN CLINICS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	45,375
2.00	ADMINISTRATIVE & GENERAL	6	148,567
3.00	OPERATION OF PLANT	8	44,915
TOTAL RECLASSIFICATIONS FOR CODE C			238,857

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
PHYSICIANS' PRIVATE OFFICES	98	238,857	
		0	
		0	
		238,857	

RECLASS CODE: D
EXPLANATION : ADVERTISING

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	109,931
TOTAL RECLASSIFICATIONS FOR CODE D			109,931

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADVERTISING	100	109,931	
		109,931	

RECLASS CODE: E
EXPLANATION : ROCHESTER CLERICAL

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	333,210
TOTAL RECLASSIFICATIONS FOR CODE E			333,210

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
PHYSICIANS' PRIVATE OFFICES	98	333,210	
		333,210	

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	345,223						345,223	
2	LAND IMPROVEMENTS	405,229						405,229	
3	BUILDINGS & FIXTURE	10,170,512					14,156	10,156,356	
4	BUILDING IMPROVEMEN	56,962	2,491,896		2,491,896		9,216	2,539,642	
5	FIXED EQUIPMENT								
6	MOVABLE EQUIPMENT	9,162,150	247,557		247,557		271,951	9,137,756	
7	SUBTOTAL	20,140,076	2,739,453		2,739,453		295,323	22,584,206	
8	RECONCILING ITEMS								
9	TOTAL	20,140,076	2,739,453		2,739,453		295,323	22,584,206	

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A-7
 I I TO 12/31/2008 I PARTS III & IV

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS CAPITLIZED GROSS ASSETS		RATIO 4	ALLOCATION OF OTHER CAPITAL			TOTAL 8
			LEASES 2	FOR RATIO 3		INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
3	NEW CAP REL COSTS-BL								
5	TOTAL				1.000000				

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	1,109,632		166,175	282,025			1,557,832
5	TOTAL	1,109,632		166,175	282,025			1,557,832

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

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	1,117,758		80,590	324,284			1,522,632
5	TOTAL	1,117,758		80,590	324,284			1,522,632

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

ADJUSTMENTS TO EXPENSES

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF.
			COST CENTER	LINE NO	
	1	2	3	4	5
1			**COST CENTER DELETED**	1	
2			**COST CENTER DELETED**	2	
3			NEW CAP REL COSTS-BLDG &	3	
4			**COST CENTER DELETED**	4	
5					
6					
7					
8					
9					
10					
11					
12	A-8-2	-795,795			
13					
14	A-8-1	67,087			
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	A-8-3				
28			**COST CENTER DELETED**	89	
29			**COST CENTER DELETED**	1	
30			**COST CENTER DELETED**	2	
31			NEW CAP REL COSTS-BLDG &	3	
32			**COST CENTER DELETED**	4	
33			**COST CENTER DELETED**	20	
34					
35	A-8-4		**COST CENTER DELETED**	51	
36	A-8-4		**COST CENTER DELETED**	52	
37	B	-3,777	ADMINISTRATIVE & GENERAL	6	
38	B	-14,512	NEW CAP REL COSTS-BLDG &	3	11
39	B	-863	NEW CAP REL COSTS-BLDG &	3	11
40	B	-1,199	NEW CAP REL COSTS-BLDG &	3	11
41	B	-15,800	ADMINISTRATIVE & GENERAL	6	
42	B	-15,800	ADMINISTRATIVE & GENERAL	6	
43	B	-14,074	ADMINISTRATIVE & GENERAL	6	
44	B	-1,550	ADMINISTRATIVE & GENERAL	6	
45	B	-5,159	ADMINISTRATIVE & GENERAL	6	
46	B	-32,467	ADMINISTRATIVE & GENERAL	6	
47	B	-566	ADMINISTRATIVE & GENERAL	6	
48	B	-2,946	ADMINISTRATIVE & GENERAL	6	
49	B	-50	DIETARY	11	
49.01	B	-28,666	DIETARY	11	
49.02	B	-9,160	DIETARY	11	
49.03	B	-112,082	CAFETERIA	12	
49.04	B	-19,089	CENTRAL SERVICES & SUPPLY	15	
49.05	B	-40,150	RESPIRATORY THERAPY	49	
49.06	B	-7,500	PHYSICAL THERAPY	50	
49.07	B	-440,968	PHARMACY	16	
49.08	B	-679,447	EMERGENCY	61	
49.09	B	-2,239	DURABLE MEDICAL EQUIP-REN	66	
49.11	A	-8,126	NEW CAP REL COSTS-BLDG &	3	9
49.12	A	-1,196,181	ANESTHESIOLOGY	40	
49.13	A	-3,110	ADMINISTRATIVE & GENERAL	6	
49.14	A	-4,495	ADMINISTRATIVE & GENERAL	6	
49.15	B	-62,863	ADMINISTRATIVE & GENERAL	6	
49.16	B	-290,017	ADMINISTRATIVE & GENERAL	6	
49.17	B	-10,303	NEW CAP REL COSTS-BLDG &	3	11
49.20					
50		-3,751,867			

(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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	3	NEW CAP REL COSTS-BLDG &	INTEREST EXPENSE	63,676	63,676	11
2	3	NEW CAP REL COSTS-BLDG &	INTEREST EXPENSE	3,411	3,411	11
3						
4						
5		TOTALS		67,087	67,087	

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	B	WOODLAWN HOSPITAL		0.00	0.00
2				0.00	0.00
3				0.00	0.00
4				0.00	0.00
5				0.00	0.00

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A-8-2
 I I TO 12/31/2008 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
41	XRAY	36,784	36,784					
49	RT	46,242	46,242					
61	ER	1,222,255	712,769	509,486				
44	LAB	29,907		29,907				
101	TOTAL	1,335,188	795,795	539,393				

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

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A-8-4
 I I TO 12/31/2008 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) 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		524.00			
10 AHSEA (SEE INSTRUCTIONS)		50.73			
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	25.37	25.37			
12 NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01 NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13 NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01 NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14 SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)
 15 THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10) 26,583
 16 ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)
 17 SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS) 26,583
 18 AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)
 19 TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)
 20 TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS) 26,583

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 50.73
 (SEE INSTRUCTIONS)
 22 WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES 39,569
 (SEE INSTRUCTIONS)
 23 TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS) 39,569

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

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

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

I PROVIDER NO: I 15-1313 I
 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I
 I PREPARED 5/28/2009 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

- 57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 39,569
- 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)
- 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
- 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)

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

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A-8-4
 I I TO 12/31/2008 I PARTS I - VII

PHYSICAL THERAPY

61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 39,569
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 29,751
 65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS) 29,751
 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) 29,751
 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000
 68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)
 68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)
 69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)

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

I PROVIDER NO: I 15-1313
 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008
 I PREPARED 5/28/2009
 I WORKSHEET A-8-4
 I PARTS I - VII

OCCUPATIONAL 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 525.00
 10 AHSEA (SEE INSTRUCTIONS) 50.73
 11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10) 25.37 25.37
 12 NUMBER OF TRAVEL HOURS
 (SEE INSTRUCTIONS)
 12.01 NUMBER OF TRAVEL HOURS OFFSITE
 (SEE INSTRUCTIONS)
 13 NUMBER OF MILES DRIVEN
 (SEE INSTRUCTIONS)
 13.01 NUMBER OF MILES DRIVEN OFFSITE
 (SEE INSTRUCTIONS)

PART II - SALARY EQUIVALENCY COMPUTATION

14 SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)
 15 THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10) 26,633
 16 ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)
 17 SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS) 26,633
 18 AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)
 19 TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)
 20 TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS) 26,633

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 50.73
 (SEE INSTRUCTIONS)
 22 WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES 39,569
 (SEE INSTRUCTIONS)
 23 TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS) 39,569

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

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

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

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A-8-4
 I I TO 12/31/2008 I PARTS I - VII

OCCUPATIONAL THERAPY

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

- 57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 39,569
- 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)
- 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
- 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)

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

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A-8-4
 I I TO 12/31/2008 I PARTS I - VII

OCCUPATIONAL THERAPY

61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 39,569
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 37,591
 65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS) 37,591
 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) 37,591
 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000
 68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)
 68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)
 69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)
 70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)

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

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A-8-4
 I I TO 12/31/2008 I PARTS I - VII

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
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		1.38		
10	AHSEA (SEE INSTRUCTIONS)		50.73		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	25.37	25.37		
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)	70
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)	70
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)	70

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)	50.72
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	39,562
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	39,562

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

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

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

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A-8-4
 I I TO 12/31/2008 I PARTS I - VII

SPEECH PATHOLOGY

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

- 57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 39,562
- 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)
- 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)
- 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

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

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET A-8-4
 I I TO 12/31/2008 I PARTS I - VII

SPEECH PATHOLOGY

61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 39,562
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 100
 65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS) 100
 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) 100
 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 5/28/2009
 I 15-1313 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				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	NOT 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	9	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	PATIENT	DAYS	ENTERED
12	CAFETERIA	11	FTE'S		ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
16	PHARMACY	15	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
	0	3	5	5a.00	6	8	9
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &	1,557,832	1,557,832					
005 EMPLOYEE BENEFITS	1,703,752	7,916	1,711,668				
006 ADMINISTRATIVE & GENERAL	3,517,171	270,874	222,261	4,010,306	4,010,306		
008 OPERATION OF PLANT	1,203,186	182,970	22,738	1,408,894	212,564	1,621,458	
009 LAUNDRY & LINEN SERVICE	103,985	6,763	1,121	111,869	16,878	10,005	138,752
010 HOUSEKEEPING	306,845	7,071	20,599	334,515	50,469	10,460	6,521
011 DIETARY	200,626	28,205	13,758	242,589	36,600	41,725	
012 CAFETERIA	261,237	57,237	21,535	340,009	51,298	84,673	
014 NURSING ADMINISTRATION	234,382	1,460	19,391	255,233	38,508	2,160	
015 CENTRAL SERVICES & SUPPLY	61,612		2,968	64,580	9,743		
016 PHARMACY	2,067,478	14,256	38,979	2,120,713	319,958	21,090	
017 MEDICAL RECORDS & LIBRARY	571,940	28,071	42,983	642,994	97,010	41,526	
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	2,958,770	249,910	248,359	3,457,039	521,574	369,700	48,425
026 INTENSIVE CARE UNIT	472,118	35,430	35,693	543,241	81,960	52,412	5,689
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	2,268,608	210,888	65,133	2,544,629	383,916	311,973	31,219
038 RECOVERY ROOM	340,211	8,031	29,379	377,621	56,973	11,881	
040 ANESTHESIOLOGY	36,386		17,751	54,137	8,168		
041 RADIOLOGY-DIAGNOSTIC	2,228,899	79,217	106,915	2,415,031	364,363	117,189	11,101
044 LABORATORY	1,666,029	31,664	64,721	1,762,414	265,901	46,841	
049 RESPIRATORY THERAPY	680,866	27,456	61,551	769,873	116,153	40,617	4,856
050 PHYSICAL THERAPY	853,518		65,472	918,990	138,651		3,191
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS							
OUTPAT SERVICE COST CNTRS							
061 EMERGENCY	1,281,891	55,373	123,421	1,460,685	220,378	81,916	25,530
062 OBSERVATION BEDS (NON-DIS							
OTHER REIMBURS COST CNTRS							
066 DURABLE MEDICAL EQUIP-REN	35,680		800	36,480	5,504		
071 HOME HEALTH AGENCY	567,704		43,912	611,616	92,276		
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	25,180,726	1,302,792	1,269,440	24,483,458	3,088,845	1,244,168	136,532
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC	5,112,642	238,843	434,996	5,786,481	873,014	353,329	2,220
099 NONPAID WORKERS							
100 ADVERTISING	297,680	16,197	7,232	321,109	48,447	23,961	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	30,591,048	1,557,832	1,711,668	30,591,048	4,010,306	1,621,458	138,752

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART I

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR
	10	11	12	ISTRATION	CES & SUPPLY	16	DS & LIBRARY
				14	15		17
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	401,965						
011 DIETARY	1,298	322,212					
012 CAFETERIA	4,541		480,521				
014 NURSING ADMINISTRATION			6,958	302,859			
015 CENTRAL SERVICES & SUPPLY			2,528		76,851		
016 PHARMACY	8,218		12,743			2,482,722	
017 MEDICAL RECORDS & LIBRARY	5,190		32,992				819,712
025 ADULTS & PEDIATRICS	188,255	301,013	124,984	173,421	3,126		212,430
026 INTENSIVE CARE UNIT	17,625	21,199	10,216	17,884	398		17,673
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	35,359		55,977	38,313	55,774		6,562
040 RECOVERY ROOM	25,411		12,066	16,074	785		
041 ANESTHESIOLOGY					852		
044 RADIOLOGY-DIAGNOSTIC LABORATORY			54,700	10,664	3,643		33,684
049 RESPIRATORY THERAPY	21,626		37,448				4,375
050 PHYSICAL THERAPY	16,760		25,695		535		19,161
055 MEDICAL SUPPLIES CHARGED			24,757		193		32,547
056 DRUGS CHARGED TO PATIENTS						2,482,722	
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	42,820		74,297	46,503	2,570		493,280
066 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS)						106	
071 DURABLE MEDICAL EQUIP-REN HOME HEALTH AGENCY						178	
095 SPEC PURPOSE COST CENTERS							
096 SUBTOTALS	367,103	322,212	475,361	302,859	68,160	2,482,722	819,712
097 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP							
099 RESEARCH							
100 PHYSICIANS' PRIVATE OFFIC	24,654				8,691		
101 NONPAID WORKERS			5,160				
102 ADVERTISING	10,208						
103 CROSS FOOT ADJUSTMENT							
104 NEGATIVE COST CENTER							
105 TOTAL	401,965	322,212	480,521	302,859	76,851	2,482,722	819,712

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART I

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
GENERAL SERVICE COST CNTR	25	26	27
003 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATION			
015 CENTRAL SERVICES & SUPPLY			
016 PHARMACY			
017 MEDICAL RECORDS & LIBRARY			
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	5,399,967		5,399,967
026 INTENSIVE CARE UNIT	768,297		768,297
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM	3,463,722		3,463,722
038 RECOVERY ROOM	500,811		500,811
040 ANESTHESIOLOGY	63,157		63,157
041 RADIOLOGY-DIAGNOSTIC	3,010,375		3,010,375
044 LABORATORY	2,138,605		2,138,605
049 RESPIRATORY THERAPY	993,650		993,650
050 PHYSICAL THERAPY	1,118,329		1,118,329
055 MEDICAL SUPPLIES CHARGED			
056 DRUGS CHARGED TO PATIENTS	2,482,722		2,482,722
061 OUTPAT SERVICE COST CNTRS EMERGENCY	2,447,979		2,447,979
062 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS)			
066 DURABLE MEDICAL EQUIP-REN	42,090		42,090
071 HOME HEALTH AGENCY	704,070		704,070
095 SPEC PURPOSE COST CENTERS SUBTOTALS	23,133,774		23,133,774
096 NONREIMBURS COST CENTERS GIFT, FLOWER, COFFEE SHOP			
097 RESEARCH			
098 PHYSICIANS' PRIVATE OFFIC	7,048,389		7,048,389
099 NONPAID WORKERS	5,160		5,160
100 ADVERTISING	403,725		403,725
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 TOTAL	30,591,048		30,591,048

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART III

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE
	0	3	4a	5	6	8	9
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS		7,916	7,916	7,916			
006 ADMINISTRATIVE & GENERAL		270,874	270,874	1,027	271,901		
008 OPERATION OF PLANT		182,970	182,970	105	14,412	197,487	
009 LAUNDRY & LINEN SERVICE		6,763	6,763	5	1,144	1,219	9,131
010 HOUSEKEEPING		7,071	7,071	95	3,422	1,274	429
011 DIETARY		28,205	28,205	64	2,481	5,082	
012 CAFETERIA		57,237	57,237	100	3,478	10,313	
014 NURSING ADMINISTRATION		1,460	1,460	90	2,611	263	
015 CENTRAL SERVICES & SUPPLY				14	661		
016 PHARMACY		14,256	14,256	180	21,693	2,569	
017 MEDICAL RECORDS & LIBRARY		28,071	28,071	199	6,577	5,058	
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		249,910	249,910	1,148	35,362	45,027	3,187
026 INTENSIVE CARE UNIT		35,430	35,430	165	5,557	6,384	374
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM		210,888	210,888	301	26,029	37,997	2,054
038 RECOVERY ROOM		8,031	8,031	136	3,863	1,447	
040 ANESTHESIOLOGY				82	554		
041 RADIOLOGY-DIAGNOSTIC		79,217	79,217	494	24,703	14,273	731
044 LABORATORY		31,664	31,664	299	18,028	5,705	
049 RESPIRATORY THERAPY		27,456	27,456	284	7,875	4,947	320
050 PHYSICAL THERAPY				303	9,400		210
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS							
061 OUTPAT SERVICE COST CNTRS EMERGENCY		55,373	55,373	570	14,941	9,977	1,680
062 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS				4	373		
066 DURABLE MEDICAL EQUIP-REN				203	6,256		
071 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS SUBTOTALS		1,302,792	1,302,792	5,868	209,420	151,535	8,985
096 NONREIMBURS COST CENTERS GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC		238,843	238,843	2,015	59,196	43,034	146
099 NONPAID WORKERS							
100 ADVERTISING		16,197	16,197	33	3,285	2,918	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		1,557,832	1,557,832	7,916	271,901	197,487	9,131

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART III

COST CENTER DESCRIPTION	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMIN ISTRATION 14	CENTRAL SERVI CES & SUPPLY 15	PHARMACY 16	MEDICAL RECOR DS & LIBRARY 17
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
008 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	12,291						
011 DIETARY	40	35,872					
012 CAFETERIA	139		71,267				
014 NURSING ADMINISTRATION			1,032	5,456			
015 CENTRAL SERVICES & SUPPLY					375		
016 PHARMACY	251		1,890		1,050		
017 MEDICAL RECORDS & LIBRARY	159		4,893			40,839	44,957
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	5,757	33,512	18,536	3,124	43		11,651
INTENSIVE CARE UNIT	539	2,360	1,515	322	5		969
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	1,081		8,302	690	762		360
040 RECOVERY ROOM	777		1,790	290	11		
041 ANESTHESIOLOGY					12		
044 RADIOLOGY-DIAGNOSTIC			8,113	192	50		1,847
049 LABORATORY	661		5,554				240
050 RESPIRATORY THERAPY	512		3,811		7		1,051
055 PHYSICAL THERAPY			3,672		3		1,785
056 MEDICAL SUPPLIES CHARGED DRUGS CHARGED TO PATIENTS						40,839	
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	1,309		11,019	838	35		27,054
066 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS)							
071 DURABLE MEDICAL EQUIP-REN HOME HEALTH AGENCY					1		
SPEC PURPOSE COST CENTERS					2		
095 SUBTOTALS	11,225	35,872	70,502	5,456	931	40,839	44,957
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP							
098 RESEARCH							
099 PHYSICIANS' PRIVATE OFFIC	754				119		
100 NONPAID WORKERS			765				
101 ADVERTISING	312						
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
TOTAL	12,291	35,872	71,267	5,456	1,050	40,839	44,957

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART III

	COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	GENERAL SERVICE COST CNTR	25	26	27
003	NEW CAP REL COSTS-BLDG &			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
009	LAUNDRY & LINEN SERVICE			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
015	CENTRAL SERVICES & SUPPLY			
016	PHARMACY			
017	MEDICAL RECORDS & LIBRARY			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	407,257		407,257
026	INTENSIVE CARE UNIT	53,620		53,620
	ANCILLARY SRVC COST CNTRS			
037	OPERATING ROOM	288,464		288,464
038	RECOVERY ROOM	16,345		16,345
040	ANESTHESIOLOGY	648		648
041	RADIOLOGY-DIAGNOSTIC	129,620		129,620
044	LABORATORY	62,151		62,151
049	RESPIRATORY THERAPY	46,263		46,263
050	PHYSICAL THERAPY	15,373		15,373
055	MEDICAL SUPPLIES CHARGED			
056	DRUGS CHARGED TO PATIENTS	40,839		40,839
	OUTPAT SERVICE COST CNTRS			
061	EMERGENCY	122,796		122,796
062	OBSERVATION BEDS (NON-DIS			
	OTHER REIMBURS COST CNTRS			
066	DURABLE MEDICAL EQUIP-REN	378		378
071	HOME HEALTH AGENCY	6,461		6,461
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	1,190,215		1,190,215
	NONREIMBURS COST CENTERS			
096	GIFT, FLOWER, COFFEE SHOP			
097	RESEARCH			
098	PHYSICIANS' PRIVATE OFFIC	344,107		344,107
099	NONPAID WORKERS	765		765
100	ADVERTISING	22,745		22,745
101	CROSS FOOT ADJUSTMENTS			
102	NEGATIVE COST CENTER			
103	TOTAL	1,557,832		1,557,832

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	NEW CAP REL	C EMPLOYEE BENE	RECONCIL-	ADMINISTRATIV	OPERATION OF	LAUNDRY & LIN
	OSTS-BLDG &	FITS		E & GENERAL	PLANT	EN SERVICE
	(SQUARE FEET)	(GROSS SALARIES)	IATION	(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)
	3	5	6a.00	6	8	9
003 GENERAL SERVICE COST						
005 NEW CAP REL COSTS-BLD	81,080					
006 EMPLOYEE BENEFITS	412	15,297,702				
008 ADMINISTRATIVE & GENE	14,098	1,986,407	-4,010,306	26,580,742		
009 OPERATION OF PLANT	9,523	203,216		1,408,894	57,047	
010 LAUNDRY & LINEN SERVI	352	10,022		111,869	352	191,918
011 HOUSEKEEPING	368	184,096		334,515	368	9,020
012 DIETARY	1,468	122,959		242,589	1,468	
014 CAFETERIA	2,979	192,464		340,009	2,979	
015 NURSING ADMINISTRATIO	76	173,300		255,233	76	
016 CENTRAL SERVICES & SU		26,523		64,580		
017 PHARMACY	742	348,366		2,120,713	742	
025 MEDICAL RECORDS & LIB	1,461	384,149		642,994	1,461	
026 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS	13,007	2,219,647		3,457,039	13,007	66,979
037 INTENSIVE CARE UNIT	1,844	319,002		543,241	1,844	7,869
038 ANCILLARY SRVC COST C						
040 OPERATING ROOM	10,976	582,113		2,544,629	10,976	43,181
041 RECOVERY ROOM	418	262,564		377,621	418	
044 ANESTHESIOLOGY		158,643		54,137		
049 RADIOLOGY-DIAGNOSTIC	4,123	955,527		2,415,031	4,123	15,354
050 LABORATORY	1,648	578,430		1,762,414	1,648	
055 RESPIRATORY THERAPY	1,429	550,101		769,873	1,429	6,717
056 PHYSICAL THERAPY		585,143		918,990		4,414
061 MEDICAL SUPPLIES CHAR						
062 DRUGS CHARGED TO PATI						
066 OUTPAT SERVICE COST C						
071 EMERGENCY	2,882	1,103,048		1,460,685	2,882	35,313
095 OBSERVATION BEDS (NON						
096 OTHER REIMBURS COST C						
098 DURABLE MEDICAL EQUIP		7,148		36,480		
099 HOME HEALTH AGENCY		392,450		611,616		
100 SPEC PURPOSE COST CEN						
101 SUBTOTALS	67,806	11,345,318	-4,010,306	20,473,152	43,773	188,847
102 NONREIMBURS COST CENT						
103 GIFT, FLOWER, COFFEE						
104 RESEARCH						
105 PHYSICIANS' PRIVATE O	12,431	3,887,749		5,786,481	12,431	3,071
106 NONPAID WORKERS						
107 ADVERTISING	843	64,635		321,109	843	
108 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	1,557,832	1,711,668		4,010,306	1,621,458	138,752
104 (WRKSHT B, PART I)						
105 UNIT COST MULTIPLIER	19.213518				28.423195	
106 (WRKSHT B, PT I)		.111891		.150873		.722975
107 COST TO BE ALLOCATED						
108 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
107 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED		7,916		271,901	197,487	9,131
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER		.000517		.010229	3.461830	.047578
108 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET B-1
 I I TO 12/31/2008 I

	COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR
		(HOURS OF SERVICE)	(PATIENT DAYS)	(FTE'S)	(DIRECT) NRSING HRS	(COSTED) REQUIS.	(COSTED) REQUIS.	(TIME SPENT)
		10	11	12	14	15	16	17
003	GENERAL SERVICE COST							
005	NEW CAP REL COSTS-BLD							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENE							
009	OPERATION OF PLANT							
010	LAUNDRY & LINEN SERVI							
011	HOUSEKEEPING	18,587						
012	DIETARY	60	3,511					
014	CAFETERIA	210		18,439				
015	NURSING ADMINISTRATIO			267	106,098			
016	CENTRAL SERVICES & SU			97		1,894,841		
017	PHARMACY	380		489			100	
025	MEDICAL RECORDS & LIB	240		1,266				9,369
026	INPAT ROUTINE SRVC CN							
037	ADULTS & PEDIATRICS	8,705	3,280	4,796	60,753	77,078		2,428
038	INTENSIVE CARE UNIT	815	231	392	6,265	9,802		202
040	ANCILLARY SRVC COST C							
041	OPERATING ROOM	1,635		2,148	13,422	1,375,210		75
044	RECOVERY ROOM	1,175		463	5,631	19,343		
049	ANESTHESIOLOGY					20,999		
050	RADIOLOGY-DIAGNOSTIC			2,099	3,736	89,812		385
055	LABORATORY	1,000		1,437				50
056	RESPIRATORY THERAPY	775		986		13,184		219
061	PHYSICAL THERAPY			950		4,758		372
062	MEDICAL SUPPLIES CHAR							
066	DRUGS CHARGED TO PATI						100	
071	OUTPAT SERVICE COST C							
095	EMERGENCY	1,980		2,851	16,291	63,362		5,638
096	OBSERVATION BEDS (NON							
097	OTHER REIMBURS COST C							
098	DURABLE MEDICAL EQUIP					2,617		
099	HOME HEALTH AGENCY					4,380		
100	SPEC PURPOSE COST CEN							
101	SUBTOTALS	16,975	3,511	18,241	106,098	1,680,545	100	9,369
102	NONREIMBURS COST CENT							
103	GIFT, FLOWER, COFFEE							
104	RESEARCH							
105	PHYSICIANS' PRIVATE O	1,140				214,296		
106	NONPAID WORKERS			198				
107	ADVERTISING	472						
108	CROSS FOOT ADJUSTMENT							
109	NEGATIVE COST CENTER							
110	COST TO BE ALLOCATED	401,965	322,212	480,521	302,859	76,851	2,482,722	819,712
111	(WRKSHT B, PART I)							
112	UNIT COST MULTIPLIER		91.772145		2.854521		24,827.220000	
113	(WRKSHT B, PT I)	21.626137		26.060036		.040558		87.491942
114	COST TO BE ALLOCATED							
115	(WRKSHT B, PART II)							
116	UNIT COST MULTIPLIER							
117	(WRKSHT B, PT II)							
118	COST TO BE ALLOCATED	12,291	35,872	71,267	5,456	1,050	40,839	44,957
119	(WRKSHT B, PART III)							
120	UNIT COST MULTIPLIER		10.217032		.051424		408.390000	
121	(WRKSHT B, PT III)	.661269		3.865014		.000554		4.798484

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 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	5,399,967		5,399,967		5,399,967
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	768,297		768,297		768,297
37	OPERATING ROOM	3,463,722		3,463,722		3,463,722
38	RECOVERY ROOM	500,811		500,811		500,811
40	ANESTHESIOLOGY	63,157		63,157		63,157
41	RADIOLOGY-DIAGNOSTIC	3,010,375		3,010,375		3,010,375
44	LABORATORY	2,138,605		2,138,605		2,138,605
49	RESPIRATORY THERAPY	993,650		993,650		993,650
50	PHYSICAL THERAPY	1,118,329		1,118,329		1,118,329
55	MEDICAL SUPPLIES CHARGED					
56	DRUGS CHARGED TO PATIENTS	2,482,722		2,482,722		2,482,722
61	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	2,447,979		2,447,979		2,447,979
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,581,694		1,581,694		1,581,694
66	DURABLE MEDICAL EQUIP-REN	42,090		42,090		42,090
101	SUBTOTAL	24,011,398		24,011,398		24,011,398
102	LESS OBSERVATION BEDS	1,581,694		1,581,694		1,581,694
103	TOTAL	22,429,704		22,429,704		22,429,704

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 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
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,857,795		2,857,795			
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	589,715		589,715			
37	OPERATING ROOM	2,072,953	4,773,157	6,846,110	.505940	.505940	.505940
38	RECOVERY ROOM	125,707	614,381	740,088	.676691	.676691	.676691
40	ANESTHESIOLOGY	95,283	423,343	518,626	.121778	.121778	.121778
41	RADIOLOGY-DIAGNOSTIC	552,624	10,262,972	10,815,596	.278336	.278336	.278336
44	LABORATORY	1,099,280	7,752,146	8,851,426	.241611	.241611	.241611
49	RESPIRATORY THERAPY	942,336	2,204,052	3,146,388	.315807	.315807	.315807
50	PHYSICAL THERAPY	153,922	1,710,704	1,864,626	.599760	.599760	.599760
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	2,375,371	6,684,038	9,059,409	.274049	.274049	.274049
61	EMERGENCY	32,562	4,219,065	4,251,627	.575775	.575775	.575775
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		1,174,276	1,174,276	1.346953	1.346953	1.346953
66	DURABLE MEDICAL EQUIP-REN		6,205	6,205	6.783239	6.783239	6.783239
101	SUBTOTAL	10,897,548	39,824,339	50,721,887			
102	LESS OBSERVATION BEDS						
103	TOTAL	10,897,548	39,824,339	50,721,887			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
I 15-1313 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	5,399,967		5,399,967		5,399,967
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	768,297		768,297		768,297
37	OPERATING ROOM	3,463,722		3,463,722		3,463,722
38	RECOVERY ROOM	500,811		500,811		500,811
40	ANESTHESIOLOGY	63,157		63,157		63,157
41	RADIOLOGY-DIAGNOSTIC	3,010,375		3,010,375		3,010,375
44	LABORATORY	2,138,605		2,138,605		2,138,605
49	RESPIRATORY THERAPY	993,650		993,650		993,650
50	PHYSICAL THERAPY	1,118,329		1,118,329		1,118,329
55	MEDICAL SUPPLIES CHARGED					
56	DRUGS CHARGED TO PATIENTS	2,482,722		2,482,722		2,482,722
61	OUTPAT SERVICE COST CNTRS EMERGENCY	2,447,979		2,447,979		2,447,979
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,581,694		1,581,694		1,581,694
66	DURABLE MEDICAL EQUIP-REN	42,090		42,090		42,090
101	SUBTOTAL	24,011,398		24,011,398		24,011,398
102	LESS OBSERVATION BEDS	1,581,694		1,581,694		1,581,694
103	TOTAL	22,429,704		22,429,704		22,429,704

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
I 15-1313 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
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,857,795		2,857,795			
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS	589,715		589,715			
37	OPERATING ROOM	2,072,953	4,773,157	6,846,110	.505940	.505940	.505940
38	RECOVERY ROOM	125,707	614,381	740,088	.676691	.676691	.676691
40	ANESTHESIOLOGY	95,283	423,343	518,626	.121778	.121778	.121778
41	RADIOLOGY-DIAGNOSTIC	552,624	10,262,972	10,815,596	.278336	.278336	.278336
44	LABORATORY	1,099,280	7,752,146	8,851,426	.241611	.241611	.241611
49	RESPIRATORY THERAPY	942,336	2,204,052	3,146,388	.315807	.315807	.315807
50	PHYSICAL THERAPY	153,922	1,710,704	1,864,626	.599760	.599760	.599760
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	2,375,371	6,684,038	9,059,409	.274049	.274049	.274049
61	EMERGENCY	32,562	4,219,065	4,251,627	.575775	.575775	.575775
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		1,174,276	1,174,276	1.346953	1.346953	1.346953
66	DURABLE MEDICAL EQUIP-REN		6,205	6,205	6.783239	6.783239	6.783239
101	SUBTOTAL	10,897,548	39,824,339	50,721,887			
102	LESS OBSERVATION BEDS						
103	TOTAL	10,897,548	39,824,339	50,721,887			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	3,463,722	288,464	3,175,258			3,463,722
38	RECOVERY ROOM	500,811	16,345	484,466			500,811
40	ANESTHESIOLOGY	63,157	648	62,509			63,157
41	RADIOLOGY-DIAGNOSTIC	3,010,375	129,620	2,880,755			3,010,375
44	LABORATORY	2,138,605	62,151	2,076,454			2,138,605
49	RESPIRATORY THERAPY	993,650	46,263	947,387			993,650
50	PHYSICAL THERAPY	1,118,329	15,373	1,102,956			1,118,329
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS	2,482,722	40,839	2,441,883			2,482,722
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,447,979	122,796	2,325,183			2,447,979
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,581,694		1,581,694			1,581,694
66	DURABLE MEDICAL EQUIP-REN	42,090	378	41,712			42,090
101	SUBTOTAL	17,843,134	722,877	17,120,257			17,843,134
102	LESS OBSERVATION BEDS	1,581,694		1,581,694			1,581,694
103	TOTAL	16,261,440	722,877	15,538,563			16,261,440

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	6,846,110	.505940	.505940
38	RECOVERY ROOM	740,088	.676691	.676691
40	ANESTHESIOLOGY	518,626	.121778	.121778
41	RADIOLOGY-DIAGNOSTIC	10,815,596	.278336	.278336
44	LABORATORY	8,851,426	.241611	.241611
49	RESPIRATORY THERAPY	3,146,388	.315807	.315807
50	PHYSICAL THERAPY	1,864,626	.599760	.599760
55	MEDICAL SUPPLIES CHARGED			
56	DRUGS CHARGED TO PATIENTS	9,059,409	.274049	.274049
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	4,251,627	.575775	.575775
62	OBSERVATION BEDS (NON-DIS	1,174,276	1.346953	1.346953
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-REN	6,205	6.783239	6.783239
101	SUBTOTAL	47,274,377		
102	LESS OBSERVATION BEDS	1,174,276		
103	TOTAL	46,100,101		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	3,463,722	288,464	3,175,258			3,463,722
38	RECOVERY ROOM	500,811	16,345	484,466			500,811
40	ANESTHESIOLOGY	63,157	648	62,509			63,157
41	RADIOLOGY-DIAGNOSTIC	3,010,375	129,620	2,880,755			3,010,375
44	LABORATORY	2,138,605	62,151	2,076,454			2,138,605
49	RESPIRATORY THERAPY	993,650	46,263	947,387			993,650
50	PHYSICAL THERAPY	1,118,329	15,373	1,102,956			1,118,329
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS	2,482,722	40,839	2,441,883			2,482,722
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,447,979	122,796	2,325,183			2,447,979
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,581,694		1,581,694			1,581,694
66	DURABLE MEDICAL EQUIP-REN	42,090	378	41,712			42,090
101	SUBTOTAL	17,843,134	722,877	17,120,257			17,843,134
102	LESS OBSERVATION BEDS	1,581,694		1,581,694			1,581,694
103	TOTAL	16,261,440	722,877	15,538,563			16,261,440

WKST A LINE 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	6,846,110	.505940	.505940
38	RECOVERY ROOM	740,088	.676691	.676691
40	ANESTHESIOLOGY	518,626	.121778	.121778
41	RADIOLOGY-DIAGNOSTIC	10,815,596	.278336	.278336
44	LABORATORY	8,851,426	.241611	.241611
49	RESPIRATORY THERAPY	3,146,388	.315807	.315807
50	PHYSICAL THERAPY	1,864,626	.599760	.599760
55	MEDICAL SUPPLIES CHARGED			
56	DRUGS CHARGED TO PATIENTS	9,059,409	.274049	.274049
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	4,251,627	.575775	.575775
62	OBSERVATION BEDS (NON-DIS	1,174,276	1.346953	1.346953
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-REN	6,205	6.783239	6.783239
101	SUBTOTAL	47,274,377		
102	LESS OBSERVATION BEDS	1,174,276		
103	TOTAL	46,100,101		

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET C
 I I TO 12/31/2008 I PART III

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	3,449,512	6,843,286			
38	RECOVERY ROOM	495,803	740,088			
40	ANESTHESIOLOGY	60,563	518,626			
41	RADIOLOGY-DIAGNOSTIC	2,991,938	10,815,596			
44	LABORATORY	2,127,307	8,851,426			
49	RESPIRATORY THERAPY	983,606	3,146,388			
50	PHYSICAL THERAPY	1,107,750	1,864,626			
55	MEDICAL SUPPLIES CHARGED	590	2,824			
56	DRUGS CHARGED TO PATIENTS	2,475,218	9,059,409			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	2,423,219	4,251,627			
62	OBSERVATION BEDS (NON-DIS	1,512,324	1,188,093			
	OTHER REIMBURS COST CNTRS					
66	DURABLE MEDICAL EQUIP-REN	41,944	6,205			
101	TOTAL	17,669,774	47,288,194			

COMPUTATION OF OUTPATIENT COST PER VISIT -
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
I 15-1313 I FROM 1/ 1/2008 I WORKSHEET C
I I TO 12/31/2008 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	3,449,512		3,449,512	6,843,286			
38	RECOVERY ROOM	495,803		495,803	740,088			
40	ANESTHESIOLOGY	60,563		60,563	518,626			
41	RADIOLOGY-DIAGNOSTIC	2,991,938	36,784	3,028,722	10,815,596			
44	LABORATORY	2,127,307		2,127,307	8,851,426			
49	RESPIRATORY THERAPY	983,606	46,242	1,029,848	3,146,388			
50	PHYSICAL THERAPY	1,107,750		1,107,750	1,864,626			
55	MEDICAL SUPPLIES CHARGED	590		590	2,824			
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	2,475,218		2,475,218	9,059,409			
61	EMERGENCY	2,423,219	712,769	3,135,988	4,251,627			
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	1,512,324		1,512,324	1,188,093			
66	DURABLE MEDICAL EQUIP-REN	41,944		41,944	6,205			
101	TOTAL	17,669,774	795,795	18,465,569	47,288,194			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART V
 I 15-1313 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.505940		.505940		
38 RECOVERY ROOM	.676691		.676691		
40 ANESTHESIOLOGY	.121778		.121778		
41 RADIOLOGY-DIAGNOSTIC	.278336		.278336		
44 LABORATORY	.241611		.241611		
49 RESPIRATORY THERAPY	.315807		.315807		
50 PHYSICAL THERAPY	.599760		.599760		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS	.274049		.274049		
61 EMERGENCY	.575775		.575775		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.346953		1.346953		
OTHER REIMBURS COST CNTRS					
66 DURABLE MEDICAL EQUIP-RENTED	6.783239		6.783239		
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 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART V
 I 15-1313 I I

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		930,089			
38 RECOVERY ROOM		114,703			
40 ANESTHESIOLOGY		70,036			
41 RADIOLOGY-DIAGNOSTIC		2,667,826			
44 LABORATORY		2,254,141			
49 RESPIRATORY THERAPY		730,145			
50 PHYSICAL THERAPY		519,744			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,799			
56 DRUGS CHARGED TO PATIENTS		2,822,308			
61 EMERGENCY		1,064,018			
62 OBSERVATION BEDS (NON-DISTINCT PART)		536,833			
66 OTHER REIMBURS COST CNTRS					
66 DURABLE MEDICAL EQUIP-RENTED					
101 SUBTOTAL		11,712,642			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		11,712,642			

(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 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D
 I COMPONENT NO: I TO 12/31/2008 I PART V
 I 15-1313 I

TITLE XVIII, PART B

HOSPITAL

All Other

Hospital I/P
Part B Charges

Hospital I/P
Part B Costs

Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM		470,569	
38 RECOVERY ROOM		77,618	
40 ANESTHESIOLOGY		8,529	
41 RADIOLOGY-DIAGNOSTIC		742,552	
44 LABORATORY		544,625	
49 RESPIRATORY THERAPY		230,585	
50 PHYSICAL THERAPY		311,722	
55 MEDICAL SUPPLIES CHARGED TO PATIENTS			
56 DRUGS CHARGED TO PATIENTS		773,451	
OUTPAT SERVICE COST CNTRS			
61 EMERGENCY		612,635	
62 OBSERVATION BEDS (NON-DISTINCT PART)		723,089	
OTHER REIMBURS COST CNTRS			
66 DURABLE MEDICAL EQUIP-RENTED			
101 SUBTOTAL		4,495,375	
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES		4,495,375	

(A) WORKSHEET A LINE NUMBERS

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2008 I PART I
 I 15-1313 I I

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,619
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,443
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,443
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	122
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	54
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,214
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	122
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	139.61
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	5,399,967
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	7,539
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	151,652
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,248,315

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,231,047
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,231,047
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.624339
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	727.22
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	5,248,315

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2008 I PART II
 I 15-1313 I I

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 1,181.25
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,434,038
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,434,038

	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	768,297	231	3,325.96	135	449,005
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
49 TOTAL PROGRAM INPATIENT COSTS					1,218,888
					3,101,931

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) 144,113
 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 144,113
 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 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2008 I PART III
 I 15-1313 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
- 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 1,339
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,181.25
- 85 OBSERVATION BED COST 1,581,694

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2008 I PART I
 I 15-1313 I I

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,619
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,443
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,443
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	122
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	54
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)	161
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	139.61
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	139.61
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	5,399,967
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	17,032
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	7,539
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	151,652
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,248,315

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,231,047
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,231,047
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.624339
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	727.22
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	5,248,315

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2008 I PART II
 I 15-1313 I I

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 1,181.25
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 190,181
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 190,181

	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	768,297	231	3,325.96		
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
49 TOTAL PROGRAM INPATIENT COSTS					104,671 294,852

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 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D-1
 I COMPONENT NO: I TO 12/31/2008 I PART III
 I 15-1313 I I

TITLE XIX - I/P HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	1,339
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,181.25
85	OBSERVATION BED COST	1,581,694

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 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-1313 I
 OTHER

TITLE XVIII, PART A HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,104,955	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		257,591	
37	OPERATING ROOM	.505940	942,431	476,814
38	RECOVERY ROOM	.676691	38,577	26,105
40	ANESTHESIOLOGY	.121778	30,238	3,682
41	RADIOLOGY-DIAGNOSTIC	.278336	267,046	74,329
44	LABORATORY	.241611	517,435	125,018
49	RESPIRATORY THERAPY	.315807	523,201	165,231
50	PHYSICAL THERAPY	.599760	84,792	50,855
55	MEDICAL SUPPLIES CHARGED TO PATIENTS			
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.274049	1,063,168	291,360
61	EMERGENCY	.575775	9,542	5,494
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	1.346953		
66	DURABLE MEDICAL EQUIP-RENTED	6.783239		
101	TOTAL		3,476,430	1,218,888
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,476,430	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-Z313 I

TITLE XVIII, PART A

SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.505940	1,309	662
38	RECOVERY ROOM	.676691	5	3
40	ANESTHESIOLOGY	.121778	93	11
41	RADIOLOGY-DIAGNOSTIC	.278336	3,148	876
44	LABORATORY	.241611	3,616	874
49	RESPIRATORY THERAPY	.315807	21,844	6,898
50	PHYSICAL THERAPY	.599760	21,897	13,133
55	MEDICAL SUPPLIES CHARGED TO PATIENTS			
56	DRUGS CHARGED TO PATIENTS	.274049	17,314	4,745
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.575775	5	3
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.346953		
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-RENTED	6.783239		
101	TOTAL		69,231	27,205
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		69,231	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET D-4
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-1313 I

TITLE XIX

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		175,085	
26	INTENSIVE CARE UNIT		14,122	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.505940	72,327	36,593
38	RECOVERY ROOM	.676691	10,538	7,131
40	ANESTHESIOLOGY	.121778	7,629	929
41	RADIOLOGY-DIAGNOSTIC	.278336	19,948	5,552
44	LABORATORY	.241611	53,730	12,982
49	RESPIRATORY THERAPY	.315807	34,642	10,940
50	PHYSICAL THERAPY	.599760	828	497
55	MEDICAL SUPPLIES CHARGED TO PATIENTS			
56	DRUGS CHARGED TO PATIENTS	.274049	95,404	26,145
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.575775	6,777	3,902
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.346953		
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-RENTED	6.783239		
101	TOTAL		301,823	104,671
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		301,823	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET E
 I COMPONENT NO: I TO 12/31/2008 I PART B
 I 15-1313 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,495,375
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)	4,495,375
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	4,540,329
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	21,004
18.01	CAH ACTUAL BILLED COINSURANCE	1,906,986
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,612,339
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	2,612,339
24	PRIMARY PAYER PAYMENTS	714
25	SUBTOTAL	2,611,625
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	266,016
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	266,016
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	257,786
28	SUBTOTAL	2,877,641
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	2,877,641
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	3,083,583
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-205,942
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 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-1313 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		2,360,248		3,197,295
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	12/18/2008	999	12/18/2008	33,759
ADJUSTMENTS TO PROVIDER .02	9/ 8/2008	945	9/ 8/2008	40,870
ADJUSTMENTS TO PROVIDER .03	9/ 1/2008	86,709		
ADJUSTMENTS TO PROVIDER .04	12/31/2008	28,072	12/31/2008	194,072
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50	12/18/2008	16,033	12/18/2008	327,721
ADJUSTMENTS TO PROGRAM .51			9/ 1/2008	54,692
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		100,692		-113,712
4 TOTAL INTERIM PAYMENTS		2,460,940		3,083,583
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		388,583		205,942
7 TOTAL MEDICARE PROGRAM LIABILITY		2,849,523		2,877,641

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

IN LIEU OF FORM CMS-2552-96 (11/1998)
 I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET E-1
 I COMPONENT NO: I TO 12/31/2008 I
 I 15-Z313 I I

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART 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		169,061		
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	9/ 1/2008	12,194	
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		12,194	NONE
4 TOTAL INTERIM PAYMENTS			181,255	
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
SUBTOTAL	.99		NONE	NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			11,040	
7 TOTAL MEDICARE PROGRAM LIABILITY			170,215	

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

IN LIEU OF FORM CMS-2552-96-E-2 (05/2004)
 I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I
 I COMPONENT NO: I TO 12/31/2008 I WORKSHEET E-2
 I 15-Z313 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	145,554	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	27,477	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	122	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	173,031	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	173,031	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	173,031	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	2,816	
14	80% OF PART B COSTS		
15	SUBTOTAL	170,215	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	170,215	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	181,255	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-11,040	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

IN LIEU OF FORM CMS-2552-96-E-3 (04/2005)
 I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2008 I PART II
 I 15-1313 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	3,101,931
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,101,931
5	PRIMARY PAYER PAYMENTS	288
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	3,132,659
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS 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	3,132,659
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	320,512
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,812,147
23	COINSURANCE	256
24	SUBTOTAL	2,811,891
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	37,632
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	37,632
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	37,449
26	SUBTOTAL	2,849,523
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	2,849,523
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,460,940
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	388,583
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET E-3
 I COMPONENT NO: I TO 12/31/2008 I PART III
 I - I I

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

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE			
1			294,852	
2				
3				
4				
5				
6			294,852	
7				
8				
9			294,852	
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10			189,207	
11			301,823	
12				
13				
14				
15				
16			491,030	
	CUSTOMARY CHARGES			
17				
18				
19				
20			491,030	
21			196,178	
22				
23			294,852	
	PROSPECTIVE PAYMENT AMOUNT			
24				
25				
26				
27				
28				
29				
30			294,852	
31				
32			294,852	
33				
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34				
35			294,852	
36				
37				
38				
38.01				
38.02				
38.03				
39				
40			294,852	
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52			294,852	
53				
54				
55			294,852	
56				
57			166,077	
57.01				

CALCULATION OF REIMBURSEMENT SETTLEMENT

IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/28/2009
I	15-1313	I	FROM 1/ 1/2008	I	WORKSHEET E-3	
I	COMPONENT NO:	I	TO 12/31/2008	I	PART III	
I	-	I		I		

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

TITLE XIX

HOSPITAL

OTHER
TITLE V OR
TITLE XIX

TITLE XVIII
SNF PPS

58 BALANCE DUE PROVIDER/PROGRAM
 59 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

1
128,775

2

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I
 I I TO 12/31/2008 I WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,641,468			
2	TEMPORARY INVESTMENTS	3,595,414			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	5,867,351			
5	OTHER RECEIVABLES	198,878			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	819,709			
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS	755,667			
10	DUE FROM OTHER FUNDS	87,287			
11	TOTAL CURRENT ASSETS	12,965,774			
FIXED ASSETS					
12	LAND	345,223			
12.01	LAND IMPROVEMENTS	2,536,896			
13	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	4,601,391			
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	7,483,510			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	437,078			
26	TOTAL OTHER ASSETS	437,078			
27	TOTAL ASSETS	20,886,362			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,899,096			
29 SALARIES, WAGES & FEES PAYABLE	1,383,824			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	582,231			
36 TOTAL CURRENT LIABILITIES	3,865,151			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	3,671,043			
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	3,671,043			
43 TOTAL LIABILITIES	7,536,194			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	13,350,168			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	13,350,168			
52 TOTAL LIABILITIES AND FUND BALANCES	20,886,362			

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		11,570,096		
2	NET INCOME (LOSS)		1,780,072		
3	TOTAL		13,350,168		
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5	ADDITIONS (CREDIT ADJUSTM				
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		13,350,168		
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		13,350,168		

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	FUND BALANCE AT BEGINNING OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5	ADDITIONS (CREDIT ADJUSTM				
6					
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 5/28/2009
 I 15-1313 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	2,780,436		2,780,436
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,780,436		2,780,436
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	450,611		450,611
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	450,611		450,611
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,231,047		3,231,047
17 00 ANCILLARY SERVICES	7,982,464	43,039,507	51,021,971
18 00 OUTPATIENT SERVICES		8,346,191	8,346,191
19 00 HOME HEALTH AGENCY		593,973	593,973
24 00			
25 00 TOTAL PATIENT REVENUES	11,213,511	51,979,671	63,193,182

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		34,342,915	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		34,342,915	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: 15-1313 I PERIOD: FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 5/28/2009 I WORKSHEET G-3 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	63,193,182
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	29,636,385
3	NET PATIENT REVENUES	33,556,797
4	LESS: TOTAL OPERATING EXPENSES	34,342,915
5	NET INCOME FROM SERVICE TO PATIENTS	-786,118
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	
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	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER OPERATING REVENUE	1,537,581
24.01	OTHER NONOPERATING REVENUE	989,530
24.02	OTHER ASSOC ETC	39,079
25	TOTAL OTHER INCOME	2,566,190
26	TOTAL	1,780,072
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,780,072

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						
5	94,286				175,254	269,540
HHA REIMBURSABLE SERVICES						
6	191,411					191,411
7	35,975					35,975
8	5,128					5,128
9	4,581					4,581
10						
11	61,069					61,069
12						
13						
13.20						
14						
HHA NONREIMBURSABLE SERVICES						
15						
16						
17						
18						
19						
20						
21						
22						
23						
23.50						
24	392,450				175,254	567,704

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10
GENERAL SERVICE COST CENTERS				
1				
2				
3				
4				
5		269,540		269,540
HHA REIMBURSABLE SERVICES				
6		191,411		191,411
7		35,975		35,975
8		5,128		5,128
9		4,581		4,581
10				
11		61,069		61,069
12				
13				
13.20				
14				
HHA NONREIMBURSABLE SERVICES				
15				
16				
17				
18				
19				
20				
21				
22				
23				
23.50				
24		567,704		567,704

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							
5	269,540					269,540	269,540
HHA REIMBURSABLE SERVICES							
6	191,411					191,411	173,036
7	35,975					35,975	32,521
8	5,128					5,128	4,636
9	4,581					4,581	4,141
10							
11	61,069					61,069	55,206
12							
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	567,704					567,704	

TOTAL

6

GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5							
HHA REIMBURSABLE SERVICES							
6	364,447						
7	68,496						
8	9,764						
9	8,722						
10							
11	116,275						
12							
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	567,704						

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				-269,540	298,164
HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE					191,411
7	PHYSICAL THERAPY					35,975
8	OCCUPATIONAL THERAPY					5,128
9	SPEECH PATHOLOGY					4,581
10	MEDICAL SOCIAL SERVICES					
11	HOME HEALTH AIDE					61,069
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)				-269,540	298,164
25	COST TO BE ALLOCATED					269,540
26	UNIT COST MULTIPLIER					.903999

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1) 0	NEW CAP REL COSTS-BLDG & 3	EMPLOYEE BEN EFITS 5	SUBTOTAL 5A	ADMINISTRATI VE & GENERAL 6	OPERATION OF PLANT 8
1 ADMIN & GENERAL			43,912	43,912	6,625	
2 SKILLED NURSING CARE	364,447			364,447	54,985	
3 PHYSICAL THERAPY	68,496			68,496	10,334	
4 OCCUPATIONAL THERAPY	9,764			9,764	1,473	
5 SPEECH PATHOLOGY	8,722			8,722	1,316	
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE	116,275			116,275	17,543	
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)	567,704		43,912	611,616	92,276	
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	LAUNDRY & LI NEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMI NISTRATION 14	CENTRAL SERV ICES & SUPPL 15
1 ADMIN & GENERAL						178
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)						178
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	PHARMACY 16	MEDICAL RECO RDS & LIBRAR 17	SUBTOTAL 25	POST STEP DOWN ADJUST 26	SUBTOTAL 27	ALLOCATED HHA A & G 28
1 ADMIN & GENERAL			50,715		50,715	
2 SKILLED NURSING CARE			419,432		419,432	32,558
3 PHYSICAL THERAPY			78,830		78,830	6,119
4 OCCUPATIONAL THERAPY			11,237		11,237	872
5 SPEECH PATHOLOGY			10,038		10,038	779
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE			133,818		133,818	10,387
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)			704,070		704,070	50,715
21 UNIT COST MULTIPLIER						0.077622

(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.

TOTAL HHA
 COSTS
 29

HHA COST CENTER	TOTAL HHA COSTS 29
1 ADMIN & GENERAL	
2 SKILLED NURSING CARE	451,990
3 PHYSICAL THERAPY	84,949
4 OCCUPATIONAL THERAPY	12,109
5 SPEECH PATHOLOGY	10,817
6 MEDICAL SOCIAL SERVICES	
7 HOME HEALTH AIDE	144,205
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)	704,070
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	NEW CAP REL COSTS-BLDG & (SQUARE FEET) 3	EMPLOYEE BEN EFITS (GROSS SALARIES) 5	RECONCILIATI ON 6A	ADMINISTRATI VE & GENERAL (ACCUM. COST) 6	OPERATION OF PLANT (SQUARE FEET) 8	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY) 9
1 ADMIN & GENERAL		392,450		43,912		
2 SKILLED NURSING CARE				364,447		
3 PHYSICAL THERAPY				68,496		
4 OCCUPATIONAL THERAPY				9,764		
5 SPEECH PATHOLOGY				8,722		
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE				116,275		
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)		392,450		611,616		
21 COST TO BE ALLOCATED		43,912		92,276		
22 UNIT COST MULTIPLIER		0.111892		0.150872		

HHA COST CENTER	HOUSEKEEPING (HOURS OF SERVICE) 10	DIETARY (PATIENT DAYS) 11	CAFETERIA (FTE'S) 12	NURSING ADMI NISTRATION (DIRECT NRSNG HRS) 14	CENTRAL SERV ICES & SUPPL (COSTED REQUIS.) 15	PHARMACY (COSTED REQUIS.) 16
1 ADMIN & GENERAL					4,380	
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)					4,380	
21 COST TO BE ALLOCATED					178	
22 UNIT COST MULTIPLIER					0.040639	

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

FOR WOODLAWN HOSPITAL

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

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	5/28/2009
I	15-1313	I	FROM 1/ 1/2008	I	WORKSHEET	H-5
I	HHA NO:	I	TO 12/31/2008	I	PART II	
I	15-7104	I		I		

HHA 1

MEDICAL RECO
RDS & LIBRAR
(TIME
SPENT)
17

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 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET H-6
 I HHA NO: I TO 12/31/2008 I PARTS I II & III
 I 15-7104 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) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS 3	TOTAL VISITS 4	AVERAGE COST PER VISIT 5	PROGRAM VISITS
							PART A 6
PATIENT SERVICES							
1 SKILLED NURSING	2	451,990		451,990	2,129	212.30	616
2 PHYSICAL THERAPY	3	84,949		84,949	800	106.19	301
3 OCCUPATIONAL THERAPY	4	12,109		12,109	151	80.19	47
4 SPEECH PATHOLOGY	5	10,817		10,817	81	133.54	22
5 MEDICAL SOCIAL SERVICES	6						
6 HOME HEALTH AIDE SERVICE	7	144,205		144,205	1,226	117.62	176
7 TOTAL		704,070		704,070	4,387		1,162

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST 12
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	PART A 9	NOT SUBJECT TO DEDUCT & COINSUR 10	
1 SKILLED NURSING		552	130,777	117,190	247,967
2 PHYSICAL THERAPY		242	31,963	25,698	57,661
3 OCCUPATIONAL THERAPY		16	3,769	1,283	5,052
4 SPEECH PATHOLOGY		20	2,938	2,671	5,609
5 MEDICAL SOCIAL SERVICES					
6 HOME HEALTH AIDE SERVICES		575	20,701	67,632	88,333
7 TOTAL		1,405	190,148	214,474	404,622

LIMITATION COST COMPUTATION	PATIENT SERVICES	1	2	3	4	PROGRAM COST LIMITS 5	PROGRAM VISITS
							PART A 6
8 SKILLED NURSING		9915					
9 PHYSICAL THERAPY		9915					
10 OCCUPATIONAL THERAPY		9915					
11 SPEECH PATHOLOGY		9915					
12 MEDICAL SOCIAL SERVICES		9915					
13 HOME HEALTH AIDE SERVICE		9915					
14 TOTAL							

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST 12
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	PART A 9	NOT SUBJECT TO DEDUCT & COINSUR 10	
8 SKILLED NURSING					
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 5/28/2009
 I 15-1313 I FROM 1/ 1/2008 I WORKSHEET H-6
 I HHA NO: I TO 12/31/2008 I PARTS I II & III
 I 15-7104 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
OTHER PATIENT SERVICES		1	2	3	4	5	6
15 COST OF MEDICAL SUPPLIES	8.00				4,380		1,648
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	PART A 9	10
15 COST OF MEDICAL SUPPLIES	2,441			
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	9915	
17 PER BENE COST LIMITATION (FRM FI)	9915	
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	.599760			COL 2, LN 2
2 OCCUPATIONAL THERAPY	51				COL 2, LN 3
3 SPEECH PATHOLOGY	52				COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55				COL 2, LN 15
5 DRUGS CHARGED TO PATIENTS	56	.274049			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 1/1/1999
			PRIOR 1/1/1998 TO 12/31/1998	1/1/1998 TO 12/31/1998	PRIOR 1/1/1998 TO 12/31/1998	1/1/1998 TO 12/31/1998	
	1	2	3	4	5	6	7
1 PHYSICAL THERAPY	2	106.19	2.01	3	3.01	4	5
2 OCCUPATIONAL THERAPY	3	80.19					
3 SPEECH PATHOLOGY	4	133.54					
4 TOTAL (SUM OF LINES 1-3)							

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	PART A SERVICES	PART B SERVICES
	1	2
10 TOTAL REASONABLE COST		
10.01 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	166,500	160,739
10.02 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS	2,677	
10.03 TOTAL PPS REIMBURSEMENT-LUPA EPISODES	1,157	612
10.04 TOTAL PPS REIMBURSEMENT-PEP EPISODES		2,514
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	1,031	
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	171,365	163,865
13 EXCESS REASONABLE COST		
14 SUBTOTAL	171,365	163,865
15 COINSURANCE BILLED TO PROGRAM PATIENTS		
16 NET COST	171,365	163,865
17 REIMBURSABLE BAD DEBTS		
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	171,365	163,865
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	171,365	163,865
23 SEQUESTRATION ADJUSTMENT		
24 SUBTOTAL	171,365	163,865
25 INTERIM PAYMENTS	171,365	163,865
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	5/28/2009
I	15-1313	I	FROM 1/ 1/2008	I	WORKSHEET	H-8
I	HHA NO:	I	TO 12/31/2008	I		
I	15-7104	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		171,365		163,865
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		
ADJUSTMENTS TO PROGRAM		.99		
SUBTOTAL			NONE	NONE
4 TOTAL INTERIM PAYMENTS		171,365		163,865
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER		.01		
TENTATIVE TO PROVIDER		.02		
TENTATIVE TO PROVIDER		.03		
TENTATIVE TO PROGRAM		.50		
TENTATIVE TO PROGRAM		.51		
TENTATIVE TO PROGRAM		.52		
TENTATIVE TO PROGRAM		.99		
SUBTOTAL			NONE	NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER		.01		
SETTLEMENT TO PROGRAM		.02		
7 TOTAL MEDICARE PROGRAM LIABILITY		171,365		163,865

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.