

CMS 339 Questionnaire - Exhibit 1  
Date Prepared: 1/28/2009 1:55:40 PM  
Data File: C:\Documents and Settings\atsb\My Documents\cr07\wch2008151326.mcr  
Fiscal Year: 09/01/2007 To 08/31/2008  
Provider Name: WEST CENTRAL COMMUNITY HOSPITAL  
Provider No: 151326

CMS-2552-96  
Page 1

Health Financial Systems  
MCRIF32

**EXHIBIT 1**  
FORM APPROVED  
OMB NO. 0938-0301

This questionnaire is required under the authority of sections 1815(a) and 1833(e) of the Social Security Act. Failure to submit this questionnaire will result in suspension of Medicare payments.

To the degree that the information in CMS-339: 1) constitutes commercial or financial information which is confidential, and/or 2) is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act.

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 0938-0301. The time required to complete this information collection is estimated to average 17 hours and 20 minutes per response, including the time to review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

**PROVIDER COST REPORT REIMBURSEMENT QUESTIONNAIRE**  
(You MUST USE Instructions For Completing This Form  
Located In PRM-II, § 1100ff.)

Provider Name: WEST CENTRAL COMMUNITY HOSPITAL

Provider Number(s): 151326

Filed with Form CMS-2552-96

Period: From: 09/01/2007

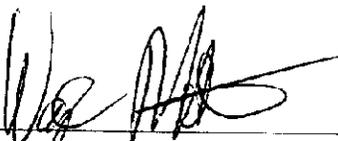
To: 08/31/2008

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

**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 information prepared by 151326 : WEST CENTRAL COMMUNITY HOSPITAL (Provider name(s) and number(s)) for the cost report period beginning 09/01/2007 and ending 08/31/2008 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(s) in accordance with applicable instructions, except as noted.

(Signed)

  
\_\_\_\_\_  
Officer or Administrator of Provider(s)

January 29, 2009  
Date

Sr Vice President/CFO  
Title

Name and Telephone Number of Person to Contact for More Information

Shantha Aaron, Controller (812)238-7655

**Street:** 801 SOUTH MAIN STREET

**State:** IN

**PO Box:**

**Zip Code:** 47842-

**City:** CLINTON

**County:** VERMILLION

**Contact:** SHANTHA AARON

**Phone:** 812-238-7655 **Ext.**

**YES/NO**

**A. Provider Organization and Operation**

NOTE: Section A to be completed by all providers.

1. The provider has:
  - a. Changed ownership. NO  
If "yes", submit name and address of new owner, date of change, copy of sales agreement, or any similar agreement affecting change of ownership.
  - b. Terminated participation. NO  
If "yes", list date of termination, and reason (Voluntary/Involuntary).
2. The provider, members of the board of directors, officers, medical staff or management personnel are associated with or involved in business transactions with the following:
  - a. Related organizations, management contracts and services under arrangements as owners (stockholders), management, by family relationship, or any other similar type relationship. NO
  - b. Management personnel of major suppliers of the provider (drug, medical supply companies, etc.). If "yes" to question 2a and/or 2b, attach a list of the individuals, the organizations involved, and description of the transactions. NO

**B. Financial Data and Reports**

NOTE: Section B to be completed by all providers.

1. During this cost reporting period, the financial statements are prepared by Certified Public Accountants or Public Accountants (submit complete copy or indicate available date) and are:
  - a. Audited; N/A
  - b. Compiled; and N/A
  - c. Reviewed. N/A

NOTE: Where there is no affirmative response to the above described financial statements, attach a copy of the financial statements prepared and a description of the changes in accounting policies and practices if not mentioned in those statements.

2. Cost report total expenses and total revenues differ from those on the filed financial statement. If "yes", submit reconciliation. NO

**C. Capital Related Cost**

NOTE: Section C to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS.

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**YES/NO**

1. Assets have been relifed for Medicare purposes. If "yes", attach detailed listing of these specific assets, by classes, as shown in the Fixed Asset Register. NO

NOTE: For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, under the capital - PPS consistency rule (42 CFR 412.302 (d)), PPS hospitals are precluded from relifing old capital.

2. Due to appraisals made during this cost reporting period, changes have occurred to Medicare depreciation expense. If "yes", attach copy of Appraisal Report and Appraisal Summary by class of asset. NO

3. New leases and/or amendments to existing leases for land, equipment, or facilities with annual rental payment in excess of the amounts listed in the instructions, have been entered into during this cost reporting period. If "yes", submit a listing of these new leases and/or amendments to existing leases that have the following information: NO

- A new lease or lease renewal;
- Parties to the lease;
- Period covered by the lease;
- Description of the asset being leased; and
- Annual charge by the lessor.

NOTE: Providers are required to submit copies of the lease, or significant extracts, upon request from the intermediary.

4. There have been new capitalized leases entered into during the current cost reporting period. If "yes", attach a list of the individual assets by class, the department assigned to, and respective dollar amounts for all capitalized leases in accordance with the thresholds discussed in the instructions. NO

5. Assets which were subject to §2314 of DEFRA were acquired during the period. If "yes", supply a computation of the basis. NO

6. Provider's capitalization policy changed during cost reporting period. If "yes", submit copy. NO

7. Obligated capital has been placed into use during the cost reporting period. If "yes", attach schedule listing each project, the cost of these projects and the date placed into service for patient care. NO

**D. Interest Expense**

NOTE: Section D to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS.

1. New loan, mortgage agreements or letters of credit were entered into during the cost reporting period. NO

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**YES/NO**

If "yes", state the purpose and submit copies of debt documents and amortization schedules.

2. The provider has a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account. NO

If "yes", submit a detailed analysis of the funded depreciation account for the cost reporting period. (See PRM-1, §226.4.)

3. Provider replaced existing debt prior to its scheduled maturity with new debt. NO

If "yes", submit support for new debt and calculation of allowable cost. (See §233.3 for description of allowable cost.)

4. Provider recalled debt before scheduled maturity without issuance of new debt. NO

If "yes", submit detail of debt cancellation costs. (See §215 for description and treatment of debt cancellation costs.)

**E. Approved Educational Activities**

NOTE: Section E to be completed by all providers.

1. Costs were claimed for Nursing School and Allied Health Programs. YES  
If "yes", attach list of the programs and annotate for each whether the provider is the legal operator of the program.

2. Approvals and/or renewals were obtained during this cost reporting period for Nursing School and/or Allied Health Programs. NO

If "yes", submit copies.

3. Provider has claimed Intern-Resident costs on the current cost report. NO  
If "yes", submit the current year Intern-Resident Information System (IRIS) on diskette.

4. Provider has initiated an Intern-Resident program in the current year or obtained a renewal of an existing program. NO

If "yes", submit certification/program approval.

5. Graduate Medical Education costs have been directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program, on Worksheet A, Form CMS-2552. NO

If "yes", submit appropriate workpapers indicating to which cost centers assigned and the amounts.

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**YES/NO**

**F. Purchased Services**

NOTE: Questions 1 and 2 to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS. Question 3 to be completed only by Inpatient PPS (IPPS) hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNFs.

- 1. Changes or new agreements have occurred in patient care services furnished through contractual arrangements with suppliers of services. NO

If "yes", submit copies of changes or contracts, or where there are no written agreements, attach description.

NOTE: Hospitals are only required to submit such information where the cost of the individual's services exceeds \$25,000 per year.

- 2. The requirements of §2135.2 were applied pertaining to competitive bidding. YES

If "no", attach explanation.

- 3. Contract services are reported on Worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNFs). YES

If "yes", submit a schedule showing the total direct patient care related contract labor, hours and calculated rate for each invoice paid during the year for the direct patient care related contract labor reported on Worksheet S-3, Part II, line 9 (hospitals) or line 17 (SNFs). Contracted labor will include any wage related costs. The contracted amounts for the top four management personnel (CEO, CFO, COO and Nursing Administrator) are not required to be reported by individuals. The total aggregate wage and hours will be reported for these management contracts. Other contracts or contracts for other management personnel should NOT be reported as they are not allowed in the computation of the wage index.

**G. Provider-Based Physicians**

NOTE: Section G to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS.

- 1. Services are furnished at the provider facility under an arrangement with provider-based physicians. YES

If "yes", submit completed provider-based physician questionnaire (Exhibits 2 through 4A).

- 2. The provider has entered into new agreements or amended existing agreements with provider-based physicians during this cost reporting period.

If "yes", submit copies of new agreements or amendments to existing agreements and assignment authorizations. NO

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**YES/NO**

**H. Home Office Costs**

NOTE: Questions 1 through 6 to be completed only by hospitals excluded from PPS (except Children's) and PPS hospitals that have a unit excluded from PPS. Question 7 to be completed only by IPPS hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNFs.

- 1. The provider is part of a chain organization. YES  
If "yes", give full name and address of the home office:

Name: UNION HOSPITAL, INC  
Address: 1606 NORTH 7TH STREET  
City: TERRE HAUTE State: IN  
Zip: 47804

Designated Intermediary: ADMINISTAR FEDERAL

- 2. A home office cost statement has been prepared by the home office. YES  
If "yes", submit a schedule displaying the entire chain's direct, functional and pooled cost as provided to the designated home office intermediary as part of the home office cost statement.

- 3. The fiscal year end of the home office is different from that of the provider. NO

If "yes", indicate the fiscal year end of the home office.  
FYE

NOTE: Where the year ends of the provider and home office are not the same (nonconcurrent year ends), the summary listing, as described in number 2 above, will be necessary to support the provider's cost report.

- 4. Describe the operation of the intercompany accounts. Include in this description the types of costs included from these intercompany accounts and their location on the cost report. (Provide informative attachments not shown on Worksheet A-8-1). NO

- 5. Actual expense amounts are transferred by the home office to the provider components on an interim basis. (Provide informative attachments if not shown on Worksheet A-8-1.) NO

- 6. The provider renders services to:
  - a. Other chain components. NO
  - b. The home office. NO
 If "yes", to either of the above, provide informative attachments.

- 7. Home Office or Related Organization personnel cost are reported on Worksheet S-3, Part II, Line 11 (hospitals) or line 18 (SNFs). YES

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**YES/NO**

If yes, submit a schedule displaying the wages, wage related costs, and hours allocated to the individual chain components as provided to the designated home office intermediary to support the amount reported on Worksheet S-3, Part II, line 11 (hospitals) or line 18 (SNFs).

**I. Bad Debts**

NOTE: Section I to be completed by all providers.

- 1. The provider seeks Medicare reimbursement for bad debts. YES  
If "yes", complete Exhibit 5 or submit internal schedules duplicating documentation required on Exhibit 5 to support bad debts claimed. (see instructions)
- 2. The provider's bad debt collection policy changed during the cost reporting period. NO  
If "yes", submit copy.
- 3. The provider waives patient deductibles and/or copayments. NO  
If yes, insure that they are not included on Exhibit 5.

**J. Bed Complement**

NOTE: Section J to be completed by all providers.

The provider's total available beds have changed from prior cost reporting period. NO  
If "yes", provide an analysis of available beds and explain any changes during the cost reporting period.

**K. PS&R Data**

NOTE 1: Section K to be completed by all providers.

NOTE 2: Refer to the instructions regarding required documentation and attachments.

- 1. The cost report was prepared using the PS&R only?
  - a) Part A (including subproviders, SNF, etc.)? YES
  - b) Part B (inpatient and outpatient). YES  
If yes, attach a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.
- 2. The cost report was prepared using the PS&R for totals and the provider records for allocation.
  - a) Part A (including subproviders, SNF, etc). NO
  - b) Part B (inpatient and outpatient). NO

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YES/NO

If yes, include a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must include which revenue codes were allocated to each cost center. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records.

If the PS&R is used for the allocation of ASC, Radiology, Other Diagnostic, and All Other Part B, explain how the total charges are detailed to the various PS&R Medicare outpatient types. Include workpapers supporting the allocation of charges into the various cost centers. If internal records are used for either the type of service breakdown or the charge allocation, the source of this information must be included in the documentation.

3. Provider records only were used to complete the cost report?

a) Part A (including subproviders, SNF, etc.).

NO

b) Part B (inpatient and outpatient).

NO

If yes, attach detailed documentation of the system used to support the data reported on the cost report.

If the detail documentation was previously supplied, submit only necessary updated documentation.

The minimum requirements are:

- Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components, capital PPS rate components, ASC payment group rates, Radiology and Other Diagnostic prevailing rates and other claims PRICING information.
- Log summaries and log detail supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R.
- Reconciliation of remittance totals to the provider consolidated log totals.

Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material.

Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

4. If yes to questions 1 or 2 above, were any of the following adjustments made to the Part A PS&R data?

Part A:

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**YES/NO**

- a) Addition of claims billed but not on PS&R? Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log. NO
- b) Correction of other PS&R information? NO
- c) Late charges? NO
- d) Other (describe)? NO

**Part B (inpatient and outpatient):**

- a) Addition of claims billed but not on PS&R? Indicate the paid claims through date from the PS&R used and the final pay date of the claims that supplement the original PS&R. Also indicate the total charges for the claims added to the PS&R. Include a summary of the unpaid claims log. NO
- b) Correction of other PS&R information? NO
- c) Late charges? NO
- d) Other (describe)? NO

Attach documentation which provides an audit trail from the PS&R to the cost report. The documentation should include the details of the PS&R, reclassifications, adjustments, and groupings necessary to trace to the cost center totals and in addition, for outpatient services, there should be an audit trail from the PS&R to the amounts shown on the cost report for outpatient charges by ASC, radiology, other diagnostic and all other service categories including standard overhead amounts and prevailing charges.

**L. Wage Related Costs**

NOTE: Section L to be completed only by IPPS hospitals, hospitals with an IPPS subprovider, hospitals that would be subject to IPPS if not granted a waiver, and SNFs.

- 1. Complete EXHIBIT 6, Part I (Per instructions). Part III must be completed to reconcile any differences between any fringe benefit cost reported on Worksheet A, Column 2, using Medicare principles and the corresponding wage related costs reported under GAAP for purposes of the wage index computation. YES
- 2. The individual wage related cost exceeds one percent of total adjusted salaries after removing excluded salaries. (Salaries reported on Worksheet S-3, Part III, Column 3, line 3 (CMS- 2552-96), or Worksheet S-3, Part II, Column 3, Line 26 2540-96).) N/A
- 3. Additional wage related costs were provided that meet ALL of the following tests: N/A

<b>Street:</b> 801 SOUTH MAIN STREET	<b>State:</b> IN
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<b>City:</b> CLINTON	<b>County:</b> VERMILLION

**Contact:** SHANTHA AARON

**Phone:** 812-238-7655                      **Ext.**

- |   | <b>YES/NO</b> |
|---|---------------|
| a.     The cost is not listed on Part I of EXHIBIT 6.   | N/A           |
| b.     If any of the additional wage related cost applies to the excluded areas of the hospital, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test in question 2 above. | N/A           |
| c.     The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS.   | N/A           |
| d.     The individual wage related cost is not included in salaries reported on Worksheet S-3, Part III, column 3, line 3, (CMS-2552-96) or Worksheet S-3, Part II, Column 3, Line 16 (CMS-2540-96).                            | N/A           |
| e.     The wage related cost is not being furnished for the convenience of the employer.  | N/A           |

[v6.1]

Date Prepared: 1/27/2009 3:54:37 PM

Data File: C:\Documents and Settings\fatsb\My Documents\cr07\wcch2008151326.mcr

Fiscal Year: 09/01/2007 To 08/31/2008

Provider Name: WEST CENTRAL COMMUNITY HOSPITAL

Health Financial Systems

Provider No: 151326

MCRIF32

**Allocation of Physician Compensation: Hours**

**Provider:** WEST CENTRAL COMMUNITY HOSPITAL

**Department:** RADIOLOGY

**Number:** 151326

**Physician:** AARON BERKEY

**Basis of Allocation:** Other

**Describe:** CONTRACTUAL

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Departmental Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	150.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C).	150.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	
4. Total Hours: (Lines 1D, 2, and 3)	150.00
6. Provider Component Percentage - (Line 1D / Line 4)	100.00%

*David R. Lora, CEO*  
 Signature: Physician or Physician Department Head

*1-28-09*  
 Date

[v6]

Date Prepared: 1/27/2009 3:55:18 PM

Data File: C:\Documents and Settings\atsb\My Documents\cr07\wcch2008151326.mcr

Fiscal Year: 09/01/2007 To 08/31/2008

Provider Name: WEST CENTRAL COMMUNITY HOSPITAL

Health Financial Systems

Provider No: 151326

MCRIF32

Allocation of Physician Compensation: Hours

Provider: WEST CENTRAL COMMUNITY HOSPITAL

Department: EMERGENCY DEPARTMENT

Number: 151326

Physician: MIDWEST MEDICAL MANAGEMENT

Basis of Allocation: Time Study

Describe:

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	
1B. Provider Services - Non Teaching Reimbursable Activities such as Departmental Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	4,800.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C).	4,800.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	
4. Total Hours: (Lines 1D, 2, and 3)	4,800.00
6. Provider Component Percentage - (Line 1D / Line 4)	100.00%

*David L. Jones, CEO*  
 Signature: Physician or Physician Department Head

*1-28-09*  
 Date

[v6]

**PART I - Wage Related Cost (Core List)**

**RETIREMENT COSTS:**

1.	401K Employer Contributions	1.	0.00
2.	Tax Sheltered Annuity (TSA) Employer Contribution	2.	0.00
3.	Qualified and Non-Qualified Pension Plan Cost	3.	
4.	Prior Year Pension Service Cost	4.	337,482.00

**PLAN ADMINISTRATIVE COSTS (Paid to External Organization):**

5.	401K/TSA Plan Administration fees	5.	
6.	Legal/Accounting/Management Fees-Pension Plan	6.	0.00
7.	Employee Managed Care Program Administration Fees	7.	

**HEALTH AND INSURANCE COSTS:**

8.	Health Insurance (Purchased or Self-Funded)	8.	1,318,287.00
9.	Prescription Drug Plan	9.	
10.	Dental, Hearing & Vision Plans	10.	12,435.00
11.	Life Insurance (If employee is owner or beneficiary)	11.	5,019.00
12.	Accident Ins. (If employee is owner or beneficiary)	12.	17,892.00
13.	Disability Ins. (If employee is owner or beneficiary)	13.	25,783.00
14.	Long-Term Care Ins. (If employee is owner or beneficiary)	14.	
15.	Workmen's Compensation Ins.	15.	50,046.00
16.	Retiree Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. This is the non-cumulative portion.)		

16.

**TAXES:**

17.	FICA-Employers Portion Only	17.	613,965.00
18.	Medicare Taxes - Employers Portion Only	18.	
19.	Unemployment Insurance	19.	8,189.00
20.	State or Federal Unemployment Taxes	20.	

**OTHER:**

21.	Executive Deferred Compensation	21.	11,296.00
22.	Day Care Cost and Allowances	22.	0.00
23.	Tuition Reimbursement	23.	34,864.00

TOTAL WAGE RELATED COST (CORE)

2,435,258.00

[v6.1]

**WEST CENTRAL COMMUNITY HOSPITAL**  
**August 31, 2008**  
**FORM HCFA 339**  
**EXHIBIT 1**

15-1326

Educational Activities:

Physical Medicine

Purchased Services:

Housekeeping  
 Biomedical Services  
 Laundry and Linen  
 Laboratory  
 Material Distribution  
 Printing

Bad Debts:

		<u>Deductible &amp; Coinsurance</u>	<u>Recoveries</u>	<u>Net</u>
Medicare – CAH				
	Inpatient	\$ 127,422	\$ 382	\$ 127,040
	Outpatient	531,819	1,604	530,215
		-----	-----	-----
		<u><u>\$ 659,241</u></u>	<u><u>\$ 1,986</u></u>	<u><u>\$ 657,255</u></u>

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	15-1326	I	FROM 9/ 1/2007	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 8/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 1/29/2009 TIME 15:02

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:  
WEST CENTRAL COMMUNITY HOSPITAL 15-1326  
FOR THE COST REPORTING PERIOD BEGINNING 9/ 1/2007 AND ENDING 8/31/2008 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.

  
\_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)  
**Sr Vice President/CFO**  
\_\_\_\_\_  
TITLE  
**January 29, 2009**  
\_\_\_\_\_  
DATE

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ECR ENCRYPTION INFORMATION  
DATE: 1/29/2009 TIME 15:02  
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DATE: 1/29/2009 TIME 15:02  
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PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1	HOSPITAL	0	477,750	551,288		0
3	SWING BED - SNF	0	24,622	0		0
100	TOTAL	0	502,372	551,288		0

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS  
 1 STREET: 801 SOUTH MAIN STREET  
 1.01 CITY: CLINTON

P.O. BOX:  
 STATE: IN ZIP CODE: 47842- COUNTY: VERMILLION

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	WEST CENTRAL COMMUNITY HOSPITAL	15-1326		3/ 1/2005	N	O	O
04.00 SWING BED - SNF	SWING BEDS	15-7326		3/ 1/2005	N	O	O

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 9/ 1/2007 TO: 8/31/2008  
 18 TYPE OF CONTROL

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL  
 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. 1
- 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N
- 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
- 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N Y
- 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 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 TERMINATION IN COL. 3. / /
- 24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COLUMN 3. / /
- 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. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N
- 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
- 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

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

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 3/ 1/2007

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

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)

	1	2	3	4
28.01				
	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

	1	2	3	4
28.02		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

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL V XVIII XIX  
 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) 1 2 3  
 2552-96 18.6.13.0 N N N

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

TITLE XIX INPATIENT SERVICES

- 38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? 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 5-H043  
 40.01 NAME: UNION HOSPITAL, INC. FI/CONTRACTOR NAME FI/CONTRACTOR #  
 40.02 STREET: 1606 NORTH SEVENTH ST P.O. BOX:  
 40.03 CITY: TERRE HAUTE STATE: IN ZIP CODE: 47804-  
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N  
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.  
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?  
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?  
 46 IF YOU ARE PARTICIPATING IN THE NHCNQ 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	OUTPATIENT	OUTPATIENT
	1	2	3	4	ASC	RADIOLOGY	DIAGNOSTIC
47.00 HOSPITAL	N	N	N	N	N	N	N

- 52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N  
 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N  
 53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0 / /  
 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /  
 54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:  
 PREMIUMS: 254,069  
 PAID LOSSES: 0  
 AND/OR SELF INSURANCE: 0  
 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N  
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N  
 56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. 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, 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

MULTICAMPUS

61.00 DOES THE HOSPITAL HAVE A MULTICAMPUS? 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

HOSPITAL AND HOSPITAL HEALTH CARE  
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 1/29/2009  
I 15-1326 I FROM 9/ 1/2007 I WORKSHEET 5-3  
I I TO 8/31/2008 I PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / TITLE V 3	O/P VISITS / TITLE XVIII 4	NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	23	8,418	64,344.00		1,615		183
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF					159		
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	23	8,418	64,344.00		1,774		183
6 INTENSIVE CARE UNIT	2	732	7,008.00		178		
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							29
12 TOTAL	25	9,150	71,352.00		1,952		212
13 RPCH VISITS							
25 TOTAL	25						
26 OBSERVATION BED DAYS							82
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX OBSERVATION ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION ADMITTED 6.01	NOT ADMITTED 6.02	-- INTERNS & RES. TOTAL 7	FTES LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			2,681				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			166				
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			2,847				
6 INTENSIVE CARE UNIT			292				
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY			186				
12 TOTAL			3,325				
13 RPCH VISITS							
25 TOTAL							
26 OBSERVATION BED DAYS	40	42	860	111	749		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET 9	--- FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	DISCHARGES TITLE XVIII 13 707	TITLE XIX 14 94	TOTAL ALL PATIENTS 15 1,354
1 ADULTS & PEDIATRICS						
2 HMO						
2 01 HMO - (IRF PPS SUBPROVIDER)						
3 ADULTS & PED-SB SNF						
4 ADULTS & PED-SB NF						
5 TOTAL ADULTS AND PEDS						
6 INTENSIVE CARE UNIT						
7 CORONARY CARE UNIT						
8 BURN INTENSIVE CARE UNIT						
9 SURGICAL INTENSIVE CARE UNIT						
11 NURSERY						
12 TOTAL		170.60		707	94	1,354
13 RPCH VISITS						
25 TOTAL		170.60				
26 OBSERVATION BED DAYS						
27 AMBULANCE TRIPS						
28 EMPLOYEE DISCOUNT DAYS						
28 01 EMP DISCOUNT DAYS -IRF						

## HOSPITAL WAGE INDEX INFORMATION

I PROVIDER NO: I PERIOD: I PREPARED 1/29/2009  
 I 15-1326 I FROM 9/ 1/2007 I WORKSHEET 5-3  
 I I TO 8/31/2008 I PARTS II & III

PART II - WAGE DATA	AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE 6
SALARIES						
1 TOTAL SALARY	8,904,829		8,904,829	354,912.00	25.09	
2 NON-PHYSICIAN ANESTHETIST PART A						
3 NON-PHYSICIAN ANESTHETIST PART B						
4 PHYSICIAN - PART A						
4.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
5 PHYSICIAN - PART B	958,580		958,580	7,097.00	135.07	
5.01 NON-PHYSICIAN - PART B						
6 INTERNS & RESIDENTS (APPRVD)						
6.01 CONTRACT SERVICES, I&R						
7 HOME OFFICE PERSONNEL						
8 SNF						
8.01 EXCLUDED AREA SALARIES		8,383	8,383	240.00	34.93	
OTHER WAGES & RELATED COSTS						
9 CONTRACT LABOR:	17,131		17,131	129.00	132.80	
9.01 PHARMACY SERVICES UNDER CONTRACT						
9.02 LABORATORY SERVICES UNDER CONTRACT						
9.03 MANAGEMENT & ADMINISTRATIVE UNDER CONTRACT						
10 CONTRACT LABOR: PHYS PART A	12,000		12,000	60.00	200.00	
10.01 TEACHING PHYSICIAN UNDER CONTRACT (SEE INSTRUCTIONS)						
11 HOME OFFICE SALARIES & WAGE RELATED COSTS	878,809		878,809	24,132.00	36.42	
12 HOME OFFICE: PHYS PART A						
12.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
WAGE RELATED COSTS						
13 WAGE-RELATED COSTS (CORE)	2,104,186		2,104,186			CMS 339
14 WAGE-RELATED COSTS (OTHER)						CMS 339
15 EXCLUDED AREAS						CMS 339
16 NON-PHYS ANESTHETIST PART A						CMS 339
17 NON-PHYS ANESTHETIST PART B						CMS 339
18 PHYSICIAN PART A						CMS 339
18.01 PART A TEACHING PHYSICIANS						CMS 339
19 PHYSICIAN PART B	226,512		226,512			CMS 339
19.01 WAGE-RELATD COSTS (RHC/FQHC)						CMS 339
20 INTERNS & RESIDENTS (APPRVD)						CMS 339
OVERHEAD COSTS - DIRECT SALARIES						
21 EMPLOYEE BENEFITS						
22 ADMINISTRATIVE & GENERAL	1,058,580		1,058,580	46,779.00	22.63	
22.01 A & G UNDER CONTRACT						
23 MAINTENANCE & REPAIRS						
24 OPERATION OF PLANT	327,476		327,476	18,281.00	17.91	
25 LAUNDRY & LINEN SERVICE						
26 HOUSEKEEPING	175,168		175,168	17,870.00	9.80	
26.01 HOUSEKEEPING UNDER CONTRACT						
27 DIETARY	275,362	-82,447	192,915	16,557.00	11.65	
27.01 DIETARY UNDER CONTRACT						
28 CAFETERIA		82,447	82,447	6,353.00	12.98	
29 MAINTENANCE OF PERSONNEL						
30 NURSING ADMINISTRATION	499,677		499,677	12,683.00	39.40	
31 CENTRAL SERVICE AND SUPPLY						
32 PHARMACY						
33 MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	191,171		191,171	11,790.00	16.21	
34 SOCIAL SERVICE						
35 OTHER GENERAL SERVICE						
PART III - HOSPITAL WAGE INDEX SUMMARY						
1 NET SALARIES	7,946,249		7,946,249	347,815.00	22.85	
2 EXCLUDED AREA SALARIES		8,383	8,383	240.00	34.93	
3 SUBTOTAL SALARIES	7,946,249	-8,383	7,937,866	347,575.00	22.84	
4 SUBTOTAL OTHER WAGES & RELATED COSTS	907,940		907,940	24,321.00	37.33	
5 SUBTOTAL WAGE-RELATED COSTS	2,104,186		2,104,186		26.51	
6 TOTAL	10,958,375	-8,383	10,949,992	371,896.00	29.44	
7 NET SALARIES						
8 EXCLUDED AREA SALARIES						
9 SUBTOTAL SALARIES						
10 SUBTOTAL OTHER WAGES & RELATED COSTS						
11 SUBTOTAL WAGE-RELATED COSTS						
12 TOTAL						
13 TOTAL OVERHEAD COSTS	2,527,434		2,527,434	130,313.00	19.40	

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD:  
I 15-1326 I FROM 9/ 1/2007 I  
I I TO 8/31/2008 I

I PREPARED 1/29/2009  
I WORKSHEET A

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		235,977	235,977		235,977
3.01	0301 NEW CAP REL COSTS-IMPROVE		209,657	209,657		209,657
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		318,968	318,968		318,968
5	0500 EMPLOYEE BENEFITS					
6.01	0610 NONPATIENT TELEPHONES		43,402	43,402		43,402
6.02	0620 DATA PROCESSING		433,878	433,878		433,878
6.03	0630 PURCHASING RECEIVING AND STORES		24,131	24,131		24,131
6.04	0640 ADMITTING	336,905	47,207	384,112		384,112
6.05	0650 CASHIERING/ACCOUNTS RECEIVABLE	41,081	418,508	459,589		459,589
6.06	0660 ADMINISTRATIVE AND GENERAL	680,594	535,141	1,215,735		1,215,735
8	0800 OPERATION OF PLANT	327,476	491,471	818,947		818,947
9	0900 LAUNDRY & LINEN SERVICE		40,108	40,108		40,108
10	1000 HOUSEKEEPING	175,168	68,777	243,945		243,945
11	1100 DIETARY	275,362	215,019	490,381	-231,620	258,761
12	1200 CAFETERIA				231,620	231,620
14	1400 NURSING ADMINISTRATION	499,677	70,147	569,824		569,824
17	1700 MEDICAL RECORDS & LIBRARY	191,171	64,779	255,950		255,950
18	1800 SOCIAL SERVICE					
24	2400 PARAMED ED PRGM-(SPECIFY) INPAT ROUTINE SRVC CNTRS				10,660	10,660
25	2500 ADULTS & PEDIATRICS	1,419,559	311,763	1,731,322		1,731,322
26	2600 INTENSIVE CARE UNIT	359,377	54,452	413,829		413,829
27	2700 CORONARY CARE UNIT					
28	2800 BURN INTENSIVE CARE UNIT					
29	2900 SURGICAL INTENSIVE CARE UNIT					
33	3300 NURSERY	85,999	16,974	102,973		102,973
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	342,278	837,169	1,179,447		1,179,447
38	3800 RECOVERY ROOM	67,332	7,006	74,338		74,338
38.01	3801 O/P TREATMENT ROOM	139,280	29,735	169,015		169,015
39	3900 DELIVERY ROOM & LABOR ROOM	171,859	28,883	200,742		200,742
41	4100 RADIOLOGY-DIAGNOSTIC	1,329,709	876,525	2,206,234		2,206,234
43	4300 RADIOISOTOPE		175,265	175,265		175,265
44	4400 LABORATORY		1,756,676	1,756,676		1,756,676
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		111,390	111,390		111,390
49	4900 RESPIRATORY THERAPY	294,484	85,703	380,187		380,187
50	5000 PHYSICAL THERAPY	265,869	61,901	327,770	-10,660	317,110
51	5100 OCCUPATIONAL THERAPY	88,206	15,680	103,886		103,886
52	5200 SPEECH PATHOLOGY	23,974	8,378	32,352		32,352
53	5300 ELECTROCARDIOLOGY	90,221	54,184	144,405		144,405
54	5400 ELECTROENCEPHALOGRAPHY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		75,008	75,008		75,008
56	5600 DRUGS CHARGED TO PATIENTS	341,982	639,414	981,396		981,396
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	10,655	1,030	11,685		11,685
60.01	6001 PHYSICIANS PRACTICES	437,059	116,941	554,000		554,000
61	6100 EMERGENCY	909,552	620,418	1,529,970		1,529,970
62	6200 OBSERVATION BEDS (NON-DISTINCT PART) SPEC PURPOSE COST CENTERS					
90	9000 OTHER CAPITAL RELATED COSTS					
95	SUBTOTALS	8,904,829	9,101,665	18,006,494	-0-	18,006,494
	NONREIMBURS COST CENTERS					
100	7950 FITNESS CENTER					
100.01	7951 MEDICAL OFFICE BUILDING					
101	TOTAL	8,904,829	9,101,665	18,006,494	-0-	18,006,494

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSESI PROVIDER NO:  
I 15-1326  
II PERIOD:  
I FROM 9/ 1/2007  
I TO 8/31/2008  
II PREPARED 1/29/2009  
I WORKSHEET A  
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-40,286	195,691
3.01	0301 NEW CAP REL COSTS-IMPROVE		209,657
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-505	318,463
5	0500 EMPLOYEE BENEFITS	1,965,544	1,965,544
6.01	0610 NONPATIENT TELEPHONES	-600	42,802
6.02	0620 DATA PROCESSING		433,878
6.03	0630 PURCHASING RECEIVING AND STORES	104,749	128,880
6.04	0640 ADMITTING		384,112
6.05	0650 CASHIERING/ACCOUNTS RECEIVABLE	356,293	815,882
6.06	0660 ADMINISTRATIVE AND GENERAL	497,937	1,713,672
8	0800 OPERATION OF PLANT	-94,082	724,865
9	0900 LAUNDRY & LINEN SERVICE		40,108
10	1000 HOUSEKEEPING		243,945
11	1100 DIETARY	4,733	263,494
12	1200 CAFETERIA	-136,227	95,393
14	1400 NURSING ADMINISTRATION	60,999	630,823
17	1700 MEDICAL RECORDS & LIBRARY	-556	255,394
18	1800 SOCIAL SERVICE		
24	2400 PARAMED ED PRGM-(SPECIFY) INPAT ROUTINE SRVC CNTRS		10,660
25	2500 ADULTS & PEDIATRICS	-44	1,731,278
26	2600 INTENSIVE CARE UNIT		413,829
27	2700 CORONARY CARE UNIT		
28	2800 BURN INTENSIVE CARE UNIT		
29	2900 SURGICAL INTENSIVE CARE UNIT		
33	3300 NURSERY		102,973
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-463,825	715,622
38	3800 RECOVERY ROOM	733	75,071
38.01	3801 O/P TREATMENT ROOM		169,015
39	3900 DELIVERY ROOM & LABOR ROOM		200,742
41	4100 RADIOLOGY-DIAGNOSTIC	-634,038	1,572,196
43	4300 RADIOISOTOPE		175,265
44	4400 LABORATORY	-637,276	1,119,400
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		111,390
49	4900 RESPIRATORY THERAPY		380,187
50	5000 PHYSICAL THERAPY	21,039	338,149
51	5100 OCCUPATIONAL THERAPY	5,291	109,177
52	5200 SPEECH PATHOLOGY	1,773	34,125
53	5300 ELECTROCARDIOLOGY	4,435	148,840
54	5400 ELECTROENCEPHALOGRAPHY	32	32
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-73	74,935
56	5600 DRUGS CHARGED TO PATIENTS	16,048	997,444
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		11,685
60.01	6001 PHYSICIANS PRACTICES	-546	553,454
61	6100 EMERGENCY		1,529,970
62	6200 OBSERVATION BEDS (NON-DISTINCT PART) SPEC PURPOSE COST CENTERS		
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	1,031,548	19,038,042
	NONREIMBURS COST CENTERS		
100	7950 FITNESS CENTER		
100.01	7951 MEDICAL OFFICE BUILDING		
101	TOTAL	1,031,548	19,038,042

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
151326	FROM 9/ 1/2007	1/29/2009
	TO 8/31/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1) COST CENTER		LINE NO	SALARY	OTHER
	1	2	3	4	5
1 CAFETERIA	A	CAFETERIA	12	82,447	149,173
2 PARAMED	B	PARAMED ED PRGM-(SPECIFY)	24	8,383	2,277
36 TOTAL RECLASSIFICATIONS				90,830	151,450

(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
151326	FROM 9/1/2007	1/29/2009
	TO 8/31/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	----- DECREASE -----				A-7 REF 10
	CODE (1) COST CENTER	LINE NO	SALARY	OTHER	
	1	6	7	8	9
1 CAFETERIA	A	DIETARY	11	82,447	149,173
2 PARAMED	B	PHYSICAL THERAPY	50	8,383	2,277
36 TOTAL RECLASSIFICATIONS				90,830	151,450

(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.

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	ACQUISITIONS		TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		BALANCES	PURCHASES	DONATION				
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	11,775				10,656	1,119	
6	MOVABLE EQUIPMENT							
7	SUBTOTAL	11,775				10,656	1,119	
8	RECONCILING ITEMS							
9	TOTAL	11,775				10,656	1,119	

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	ACQUISITIONS		TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		BALANCES	PURCHASES	DONATION				
		1	2	3	4	5	6	7
1	LAND	198,870	66,360		66,360		265,230	
2	LAND IMPROVEMENTS	154,564	1,991		1,991		156,555	
3	BUILDINGS & FIXTURE	4,670,141					4,670,141	
4	BUILDING IMPROVEMEN	2,243,909	1,153,636		1,153,636	12,186	3,385,359	
5	FIXED EQUIPMENT	3,494,103	599,854		599,854	281,803	3,812,154	
6	MOVABLE EQUIPMENT	17,506					17,506	
7	SUBTOTAL	10,779,093	1,821,841		1,821,841	293,989	12,306,945	
8	RECONCILING ITEMS							
9	TOTAL	10,779,093	1,821,841		1,821,841	293,989	12,306,945	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	GROSS ASSETS	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
*	1	2	3	4	5	6	7	8
3 NEW CAP REL COSTS-BL								
3 01 NEW CAP REL COSTS-IM								
4 NEW CAP REL COSTS-MV								
5 TOTAL				1.000000				

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*	9	10	11	12	13	14	15
3 NEW CAP REL COSTS-BL	195,691						195,691
3 01 NEW CAP REL COSTS-IM	209,657						209,657
4 NEW CAP REL COSTS-MV	318,463						318,463
5 TOTAL	723,811						723,811

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*	9	10	11	12	13	14	15
3 NEW CAP REL COSTS-BL	235,977						235,977
3 01 NEW CAP REL COSTS-IM	209,657						209,657
4 NEW CAP REL COSTS-MV	318,968						318,968
5 TOTAL	764,602						764,602

\* 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

I PROVIDER NO:  
I 15-1326  
I

I PERIOD:  
I FROM 9/ 1/2007 I PREPARED 1/29/2009  
I TO 8/31/2008 I WORKSHEET A-8

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			NEW CAP REL COSTS-MVBLE E	4	
5					
6	B	-91	PURCHASING RECEIVING AND	6.03	
7					
8					
9					
10					
11					
12	A-8-2	-664,140			
13					
14	A-8-1	2,766,909			
15					
16	B	-146,048	CAFETERIA	12	
17					
18					
19					
20	B	-7,193	MEDICAL RECORDS & LIBRARY	17	
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			NEW CAP REL COSTS-MVBLE E	4	
33			**COST CENTER DELETED**	20	
34					
35	A-8-4		OCCUPATIONAL THERAPY	51	
36	A-8-4		SPEECH PATHOLOGY	52	
37	A	-8,380	ADMINISTRATIVE AND GENERA	6.06	
38	A	-473,314	OPERATING ROOM	37	
39	A	-40,286	NEW CAP REL COSTS-BLDG &	3	9
40	B	-144,630	OPERATION OF PLANT	8	
41	B	-50	ADMINISTRATIVE AND GENERA	6.06	
42	B	-546	PHYSICIANS PRACTICES	60.01	
43	B	-505	NEW CAP REL COSTS-MVBLE E	4	9
44	B	-1,082	NURSING ADMINISTRATION	14	
45	B	-44	ADULTS & PEDIATRICS	25	
46	B	-73	MEDICAL SUPPLIES CHARGED	55	
47	B	-19,438	RADIOLOGY-DIAGNOSTIC	41	
48	B	-600	NONPATIENT TELEPHONES	6.01	
49	B	-3,428	DRUGS CHARGED TO PATIENTS	56	
49.01	B	-172	CASHIERING/ACCOUNTS RECEI	6.05	
49.02	A	-378	ADMINISTRATIVE AND GENERA	6.06	
49.03	B	-2,513	CAFETERIA	12	
49.04	A	-222,450	ADMINISTRATIVE AND GENERA	6.06	
50		1,031,548			

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.	
1	2	3	4	5	6		
1	44	LABORATORY	LAB	1,119,400	1,756,676	-637,276	
2	37	OPERATING ROOM	HOME OFFICE	9,489		9,489	
3	38	RECOVERY ROOM	HOME OFFICE	733		733	
4	41	RADIOLOGY-DIAGNOSTIC	HOME OFFICE	49,540		49,540	
4.01	50	PHYSICAL THERAPY	HOME OFFICE	21,039		21,039	
4.02	51	OCCUPATIONAL THERAPY	HOME OFFICE	5,291		5,291	
4.03	52	SPEECH PATHOLOGY	HOME OFFICE	1,773		1,773	
4.04	53	ELECTROCARDIOLOGY	HOME OFFICE	4,435		4,435	
4.05	54	ELECTROENCEPHALOGRAPHY	HOME OFFICE	32		32	
4.06	56	DRUGS CHARGED TO PATIENTS	HOME OFFICE	19,476		19,476	
4.07	8	OPERATION OF PLANT	HOME OFFICE	50,548		50,548	
4.08	11	DIETARY	HOME OFFICE	4,733		4,733	
4.09	12	CAFETERIA	HOME OFFICE	12,334		12,334	
4.10	6 3	PURCHASING RECEIVING AND	HOME OFFICE	104,840		104,840	
4.11	14	NURSING ADMINISTRATION	HOME OFFICE	62,081		62,081	
4.12	5	EMPLOYEE BENEFITS	HOME OFFICE	1,965,544		1,965,544	
4.13	17	MEDICAL RECORDS & LIBRARY	HOME OFFICE	6,637		6,637	
4.14	6 5	CASHIERING/ACCOUNTS RECEI	HOME OFFICE	356,465		356,465	
4.15	6 6	ADMINISTRATIVE AND GENERA	HOME OFFICE	729,195		729,195	
5		TOTALS		4,523,585	1,756,676	2,766,909	

\* 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	G	LAB		0.00	0.00
2	G	UNION HOSPITAL, INC.		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.  
LAB

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:  
I 15-1326  
I

I PERIOD:  
I FROM 9/ 1/2007  
I TO 8/31/2008

I PREPARED 1/29/2009  
I WORKSHEET A-8-2  
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	41	AGGREGATE	676,140	664,140	12,000			
2	61	AGGREGATE	379,800		379,800			
3								
4								
5								
6								
7								
8								
9								
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22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,055,940	664,140	391,800				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 1/29/2009  
 I 15-1326 I FROM 9/ 1/2007 I WORKSHEET A-8-2  
 I I TO 8/31/2008 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1	41	AGGREGATE						
2	61	AGGREGATE						664,140
3								
4								
5								
6								
7								
8								
9								
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12								
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14								
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17								
18								
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21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101		TOTAL						664,140

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NLW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-IMPROVE	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	NONPATIENT TELEPHONES	TELE DATA PROCESSING
	0	3	3.01	4	5	6.01	6.02
003 GENERAL SERVICE COST CNTR							
003 01 NEW CAP REL COSTS-BLDG &	195,691	195,691					
004 01 NEW CAP REL COSTS-IMPROVE	209,657		209,657				
004 04 NEW CAP REL COSTS-MVBLE E	318,463			318,463			
005 EMPLOYEE BENEFITS	1,965,544				1,965,544		
006 01 NONPATIENT TELEPHONES	42,802	227	244	8,419		51,692	
006 02 DATA PROCESSING	433,878	444	475	5,366		560	440,723
006 03 PURCHASING RECEIVING AND	128,880	1,384	1,483	656		373	3,061
006 04 ADMITTING	384,112	1,920	2,057	241	74,364	1,120	15,303
006 05 CASHIERING/ACCOUNTS RECEI	815,882	652	698		9,068	1,120	9,182
006 06 ADMINISTRATIVE AND GENERA	1,713,672	3,660	3,921	21,021	150,226	4,106	79,574
008 OPERATION OF PLANT	724,865	47,297	50,674	9,637	72,283	4,106	9,182
009 LAUNDRY & LINEN SERVICE	40,108	881	944	526			
010 HOUSEKEEPING	243,945	857	918	1,145	38,664	187	3,061
011 DIETARY	263,494	9,585	10,269	17,015	42,582	1,120	9,182
012 CAFETERIA	95,393				18,198		
014 NURSING ADMINISTRATION	630,823	2,551	2,734	11,588	110,293	560	12,242
017 MEDICAL RECORDS & LIBRARY	255,394	1,913	2,050	1,763	42,197	1,680	30,606
018 SOCIAL SERVICE							
024 PARAMED ED PRGM-(SPECIFY)	10,660				1,850		
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	1,731,278	28,468	30,500	20,023	313,336	15,671	42,848
026 INTENSIVE CARE UNIT	413,829	896	960	12,397	79,325	933	
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
033 NURSERY	102,973	1,972	2,113	3,683	18,982	187	
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	715,622	6,222	6,666	72,440	75,550	1,306	15,303
038 RECOVERY ROOM	75,071	658	705	3,978	14,862	373	
038 01 O/P TREATMENT ROOM	169,015	3,516	3,767	2,446	30,743	560	3,061
039 DELIVERY ROOM & LABOR ROO	200,742	1,432	1,534	8,259	37,934	187	
041 RADIOLOGY-DIAGNOSTIC	1,572,196	12,932	13,855	30,481	293,504	2,799	39,787
043 RADIOISOTOPE	175,265	575	616			187	
044 LABORATORY	1,119,400	3,433	3,677			1,120	15,303
046 WHOLE BLOOD & PACKED RED	111,390						
049 RESPIRATORY THERAPY	380,187	2,250	2,410	11,481	65,001	1,120	15,303
050 PHYSICAL THERAPY	338,149	7,388	7,915	25,004	56,834	2,239	30,606
051 OCCUPATIONAL THERAPY	109,177	6,214	6,657	559	19,470	1,493	
052 SPEECH PATHOLOGY	34,125	840	899		5,292	187	15,303
053 ELECTROCARDIOLOGY	148,840	704	754	6,194	19,914	560	
054 ELECTROENCEPHALOGRAPHY	32						
055 MEDICAL SUPPLIES CHARGED	74,935	2,221	2,380	56		373	
056 DRUGS CHARGED TO PATIENTS	997,444	2,217	2,375	7,206	75,485	933	12,242
060 01 CLINIC	11,685	175	187		2,352		
060 01 PHYSICIANS PRACTICES	553,454	7,508	8,041	991	96,471	2,986	39,787
061 EMERGENCY	1,529,970	12,560	13,457	26,573	200,764	3,546	39,787
062 OBSERVATION BEDS (NON-DIS							
062 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	19,038,042	173,552	185,938	309,148	1,965,544	51,692	440,723
100 NONREIMBURS COST CENTERS							
100 01 FITNESS CENTER							
100 01 MEDICAL OFFICE BUILDING		22,139	23,719	9,315			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	19,038,042	195,691	209,657	318,463	1,965,544	51,692	440,723

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	PURCHASING RECEIVING AND	RE ADMITTING	CASHIERING/ACCOUNTS RECEI	SUBTOTAL	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
	6.03	6.04	6.05	6a.05	6.06	8	9
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
003 01 NEW CAP REL COSTS-IMPROVE							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING RECEIVING AND	135,837						
006 04 ADMITTING	534	479,651					
006 05 CASHIERING/ACCOUNTS RECEI	71		836,673				
006 06 ADMINISTRATIVE AND GENERA	441			1,976,621	1,976,621		
008 OPERATION OF PLANT	187			918,231	106,380	1,024,611	
009 LAUNDRY & LINEN SERVICE				42,459	4,919	7,653	55,031
010 HOUSEKEEPING	1,116			289,893	33,585	7,444	1,138
011 DIETARY	275			353,522	40,957	83,250	
012 CAFETERIA				113,591	13,160		
014 NURSING ADMINISTRATION	5			770,796	89,299	22,161	
017 MEDICAL RECORDS & LIBRARY	533			336,136	38,942	16,616	
018 SOCIAL SERVICE							
024 PARAMED ED PRGM-(SPECIFY)				12,510	1,449		
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	7,165	29,005	50,593	2,268,887	262,857	247,260	20,033
026 INTENSIVE CARE UNIT	1,338	5,289	9,226	524,193	60,729	7,786	
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
033 NURSERY	878	2,007	3,501	136,296	15,790	17,128	
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	102,436	39,134	68,262	1,102,941	127,779	54,044	6,632
038 RECOVERY ROOM		3,391	5,915	104,953	12,159	5,716	
038 01 Q/P TREATMENT ROOM	676	1,777	3,100	218,661	25,333	30,535	
039 DELIVERY ROOM & LABOR ROO	2,035	5,846	10,197	268,166	31,068	12,438	
041 RADIOLOGY-DIAGNOSTIC	3,852	109,956	191,815	2,271,177	263,128	112,322	5,014
043 RADIOISOTOPE	54	6,082	10,608	193,387	22,404	4,994	72
044 LABORATORY		76,273	133,042	1,352,248	156,662	29,813	
046 WHOLE BLOOD & PACKED RED		1,156	2,017	114,563	13,272		
049 RESPIRATORY THERAPY	5,070	6,909	12,051	501,782	58,133	19,540	
050 PHYSICAL THERAPY	763	12,490	21,786	503,174	58,294	64,165	8,544
051 OCCUPATIONAL THERAPY		3,141	5,479	152,190	17,632	53,968	
052 SPEECH PATHOLOGY		1,052	1,835	59,533	6,897	7,292	
053 ELECTROCARDIOLOGY	304	16,402	28,610	222,282	25,752	6,115	2,288
054 ELECTROENCEPHALOGRAPHY		69	121	222	26		
055 MEDICAL SUPPLIES CHARGED	88	2,574	4,490	87,117	10,093	19,293	
056 DRUGS CHARGED TO PATIENTS	311	65,238	113,795	1,277,246	147,973	19,255	
OUTPUT SERVICE COST CNTRS							
060 CLINIC		189	329	14,917	1,728	1,519	
060 01 PHYSICIANS PRACTICES	713	6,662	11,620	728,236	84,368	65,210	
061 EMERGENCY	6,992	85,009	148,281	2,066,939	239,461	109,094	11,310
062 OBSERVATION BEDS (NON-DIS							
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	135,837	479,651	836,673	18,982,869	1,970,229	1,024,611	55,031
NONREIMBURS COST CENTERS							
100 FITNESS CENTER							
100 01 MEDICAL OFFICE BUILDING				55,173	6,392		
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	135,837	479,651	836,673	19,038,042	1,976,621	1,024,611	55,031

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM-(SPECIFY)
	10	11	12	14	17	18	24
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
003 01 NEW CAP REL COSTS-IMPROVE							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING RECEIVING AND							
006 04 ADMITTING							
006 05 CASHIERING/ACCOUNTS RECEI							
006 06 ADMINISTRATIVE AND GENERA							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	332,060						
011 DIETARY	27,383	505,112					
012 CAFETERIA			126,751				
014 NURSING ADMINISTRATION	7,289		6,958	896,503			
017 MEDICAL RECORDS & LIBRARY	5,465		6,102		403,261		
018 SOCIAL SERVICE							
024 PARAMED ED PRGM-(SPECIFY)							13,959
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	81,332	373,435	33,828	643,851	36,382		
026 INTENSIVE CARE UNIT	2,561	38,318	5,674	107,988	6,635		
027 CORONARY CARE UNLT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
033 NURSERY	5,634		1,606	30,563	2,517		
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	17,777		6,637	50,938	49,088		
038 RECOVERY ROOM	1,880		1,071	63,163	4,254		
038 01 O/P TREATMENT ROOM	10,044	93,359	2,676		2,229		
039 DELIVERY ROOM & LABOR ROO	4,091		3,319		7,333		
041 RADIOLOGY-DIAGNOSTIC	36,946		14,666		137,937		
043 RADIOISOTOPE	1,643						
044 LABORATORY	9,807						
046 WHOLE BLOOD & PACKED RED							
049 RESPIRATORY THERAPY	6,427		4,817		8,666		
050 PHYSICAL THERAPY	21,106		5,139		15,667		13,959
051 OCCUPATIONAL THERAPY	17,752		1,713		3,940		
052 SPEECH PATHOLOGY	2,399		321		1,320		
053 ELECTROCARDIOLOGY	2,011		1,606		20,574		
054 ELECTROENCEPHALOGRAPHY					87		
055 MEDICAL SUPPLIES CHARGED	6,346						
056 DRUGS CHARGED TO PATIENTS	6,334		5,353				
OUTPAT SERVICE COST CNTRS							
060 CLINIC	500		214				
060 01 PHYSICIANS PRACTICES	21,449		7,494				
061 EMERGENCY	35,884		17,557		106,632		
062 OBSERVATION BEDS (NON-DIS							
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	332,060	505,112	126,751	896,503	403,261		13,959
NONREIMBURS COST CENTERS							
100 FITNESS CENTER							
100 01 MEDICAL OFFICE BUILDING							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	332,060	505,112	126,751	896,503	403,261		13,959

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	25	26	27
GENERAL SERVICE COST CNTR			
003 NEW CAP REL COSTS-BLDG &			
003 01 NEW CAP REL COSTS-IMPROVE			
004 NEW CAP REL COSTS-MVBLE E			
005 EMPLOYEE BENEFITS			
006 01 NONPATIENT TELEPHONES			
006 02 DATA PROCESSING			
006 03 PURCHASING RECEIVING AND			
006 04 ADMITTING			
006 05 CASHIERING/ACCOUNTS RECEI			
006 06 ADMINISTRATIVE AND GENERA			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATION			
017 MEDICAL RECORDS & LIBRARY			
018 SOCIAL SERVICE			
024 PARAMED ED PRGM-(SPECIFY)			
INPAT ROUTINE SRVC CNTRS			
025 ADULTS & PEDIATRICS	3,967,865		3,967,865
026 INTENSIVE CARE UNIT	753,884		753,884
027 CORONARY CARE UNIT			
028 BURN INTENSIVE CARE UNIT			
029 SURGICAL INTENSIVE CARE U			
033 NURSERY	209,534		209,534
ANCILLARY SRVC COST CNTRS			
037 OPERATING ROOM	1,415,836		1,415,836
038 RECOVERY ROOM	193,196		193,196
038 01 O/P TREATMENT ROOM	382,837		382,837
039 DELIVERY ROOM & LABOR ROO	326,415		326,415
041 RADIOLOGY-DIAGNOSTIC	2,841,190		2,841,190
043 RADIOISOTOPE	222,500		222,500
044 LABORATORY	1,548,530		1,548,530
046 WHOLE BLOOD & PACKED RED	127,835		127,835
049 RESPIRATORY THERAPY	599,365		599,365
050 PHYSICAL THERAPY	690,048		690,048
051 OCCUPATIONAL THERAPY	247,195		247,195
052 SPEECH PATHOLOGY	77,762		77,762
053 ELECTROCARDIOLOGY	280,628		280,628
054 ELECTROENCEPHALOGRAPHY	335		335
055 MEDICAL SUPPLIES CHARGED	122,849		122,849
056 DRUGS CHARGED TO PATIENTS	1,456,161		1,456,161
OUTPAT SERVICE COST CNTRS			
060 CLINIC	18,878		18,878
060 01 PHYSICIANS PRACTICES	906,757		906,757
061 EMERGENCY	2,586,877		2,586,877
062 OBSERVATION BEDS (NON-DIS			
SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	18,976,477		18,976,477
NONREIMBURS COST CENTERS			
100 FITNESS CENTER			
100 01 MEDICAL OFFICE BUILDING	61,565		61,565
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 TOTAL	19,038,042		19,038,042

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-IMPROVE	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	NONPATIENT TELEPHONES
	0	3	3.01	4	4a	5	6.01
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
003 01 NEW CAP REL COSTS-IMPROVE							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES		227	244	8,419	8,890		8,890
006 02 DATA PROCESSING		444	475	5,366	6,285		96
006 03 PURCHASING RECEIVING AND		1,384	1,483	656	3,523		64
006 04 ADMITTING	825	1,920	2,057	241	5,043		193
006 05 CASHIERING/ACCOUNTS RECEI		652	698		1,350		193
006 06 ADMINISTRATIVE AND GENERA	2,440	3,660	3,921	21,021	31,042		706
008 OPERATION OF PLANT	2,108	47,297	50,674	9,637	109,716		706
009 LAUNDRY & LINEN SERVICE		881	944	526	2,351		
010 HOUSEKEEPING		857	918	1,145	2,920		32
011 DIETARY		9,585	10,269	17,015	36,869		193
012 CAFETERIA							
014 NURSING ADMINISTRATION	257	2,551	2,734	11,588	17,130		96
017 MEDICAL RECORDS & LIBRARY	5,230	1,913	2,050	1,763	10,956		289
018 SOCIAL SERVICE							
024 PARAMED ED PRGM-(SPECIFY)							
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	1,586	28,468	30,500	20,023	80,577		2,696
026 INTENSIVE CARE UNIT		896	960	12,397	14,253		160
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
033 NURSERY		1,972	2,113	3,683	7,768		32
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	40,524	6,222	6,666	72,440	125,852		225
038 RECOVERY ROOM	17	658	705	3,978	5,358		64
038 01 O/P TREATMENT ROOM		3,516	3,767	2,446	9,729		96
039 DELIVERY ROOM & LABOR ROO		1,432	1,534	8,259	11,225		32
041 RADIOLOGY-DIAGNOSTIC	337,183	12,932	13,855	30,481	394,451		481
043 RADIOISOTOPE		575	616		1,191		32
044 LABORATORY	53,122	3,433	3,677		60,232		193
046 WHOLE BLOOD & PACKED RED							
049 RESPIRATORY THERAPY	11,255	2,250	2,410	11,481	27,396		193
050 PHYSICAL THERAPY	421	7,388	7,915	25,004	40,728		385
051 OCCUPATIONAL THERAPY	215	6,214	6,657	559	13,645		257
052 SPEECH PATHOLOGY		840	899		1,739		32
053 ELECTROCARDIOLOGY	27,850	704	754	6,194	35,502		96
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED	250	2,221	2,380	56	4,907		64
056 DRUGS CHARGED TO PATIENTS	84,435	2,217	2,375	7,206	96,233		160
OUTPAT SERVICE COST CNTRS							
060 CLINIC		175	187		362		
060 01 PHYSICIANS PRACTICES	3,207	7,508	8,044	991	19,750		514
061 EMERGENCY	1,163	12,560	13,457	26,573	53,753		610
062 OBSERVATION BEDS (NON-DIS							
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	572,088	173,552	185,938	309,148	1,240,726		8,890
NONREIMBURS COST CENTERS							
100 FITNESS CENTER							
100 01 MEDICAL OFFICE BUILDING		22,139	23,719	9,315	55,173		
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	572,088	195,691	209,657	318,463	1,295,899		8,890

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DATA PROCESSING	PURCHASING RECEIVING AND	RE ADMITTING	CASHIERING/AC COUNTS RECEI	ADMINISTRATIVE AND GENERA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
	6.02	6.03	6.04	6.05	6.06	8	9
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
003 01 NEW CAP REL COSTS-IMPROVE							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING	6,381						
006 03 PURCHASING RECEIVING AND	44	3,631					
006 04 ADMITTING	222	14	5,472				
006 05 CASHIERING/ACCOUNTS RECEI	133	2		1,678			
006 06 ADMINISTRATIVE AND GENERA	1,152	12			32,912		
008 OPERATION OF PLANT	133	5			1,771	112,331	
009 LAUNDRY & LINEN SERVICE					82	839	3,272
010 HOUSEKEEPING	44	30			559	816	68
011 DIETARY	133	7			682	9,127	
012 CAFETERIA					219		
014 NURSING ADMINISTRATION	177				1,487	2,430	
017 MEDICAL RECORDS & LIBRARY	443	14			648	1,822	
018 SOCIAL SERVICE							
024 PARAMED ED PRGM-(SPECIFY)					24		
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	620	192	332	102	4,377	27,105	1,192
026 INTENSIVE CARE UNIT		36	61	19	1,011	854	
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
033 NURSERY		23	23	7	263	1,878	
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	222	2,740	448	137	2,128	5,925	394
038 RECOVERY ROOM			39	12	202	627	
038 01 O/P TREATMENT ROOM	44	18	20	6	422	3,348	
039 DELIVERY ROOM & LABOR ROO		54	67	21	517	1,364	
041 RADIOLOGY-DIAGNOSTIC	576	103	1,237	380	4,382	12,314	298
043 RADIOISOTOPE		1	70	21	373	548	4
044 LABORATORY	222		874	268	2,608	3,269	
046 WHOLE BLOOD & PACKED RED			13	4	221		
049 RESPIRATORY THERAPY	222	136	79	24	968	2,142	
050 PHYSICAL THERAPY	443	20	143	44	971	7,035	508
051 OCCUPATIONAL THERAPY			36	11	294	5,917	
052 SPEECH PATHOLOGY	222		12	4	115	799	
053 ELECTROCARDIOLOGY		8	188	58	429	670	136
054 ELECTROENCEPHALOGRAPHY			1				
055 MEDICAL SUPPLIES CHARGED		2	29	9	168	2,115	
056 DRUGS CHARGED TO PATIENTS	177	8	748	229	2,464	2,111	
OUTPAT SERVICE COST CNTRS							
060 CLINIC			2	1	29	167	
060 01 PHYSICIANS PRACTICES	576	19	76	23	1,405	7,149	
061 EMERGENCY	576	187	974	298	3,987	11,960	672
062 OBSERVATION BEDS (NON-DIS							
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	6,381	3,631	5,472	1,678	32,806	112,331	3,272
NONREIMBURS COST CENTERS							
100 FITNESS CENTER							
100 01 MEDICAL OFFICE BUILDING					106		
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	6,381	3,631	5,472	1,678	32,912	112,331	3,272

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINISTRATION 14	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	PARAMED ED PRGM-(SPECIFY) 24
GENERAL SERVICE COST CNTR							
003 NEW CAP REL COSTS-BLDG &							
003 01 NEW CAP REL COSTS-IMPROVE							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING RECEIVING AND							
006 04 ADMITTING							
006 05 CASHIERING/ACCOUNTS RECEI							
006 06 ADMINISTRATIVE AND GENERA							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	4,469						
011 DIETARY	369	47,380					
012 CAFETERIA			219				
014 NURSING ADMINISTRATION	98		12	21,430			
017 MEDICAL RECORDS & LIBRARY	74		11		14,257		
018 SOCIAL SERVICE							
024 PARAMED ED PRGM-(SPECIFY)							24
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	1,095	35,029	58	15,390	1,287		
026 INTENSIVE CARE UNIT	34	3,594	10	2,581	235		
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
033 NURSERY	76		3	731	89		
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	239		11	1,218	1,737		
038 RECOVERY ROOM	25		2	1,510	151		
038 01 O/P TREATMENT ROOM	135	8,757	5		79		
039 DELIVERY ROOM & LABOR ROO	55		6		259		
041 RADIOLOGY-DIAGNOSTIC	497		25		4,869		
043 RADIOISOTOPE	22						
044 LABORATORY	132						
046 WHOLE BLOOD & PACKED RED							
049 RESPIRATORY THERAPY	87		8		307		
050 PHYSICAL THERAPY	284		9		554		
051 OCCUPATIONAL THERAPY	239		3		139		
052 SPEECH PATHOLOGY	32		1		47		
053 ELECTROCARDIOLOGY	27		3		728		
054 ELECTROENCEPHALOGRAPHY					3		
055 MEDICAL SUPPLIES CHARGED	85						
056 DRUGS CHARGED TO PATIENTS	85		9				
OUTPAT SERVICE COST CNTRS							
060 CLINIC	7						
060 01 PHYSICIANS PRACTICES	289		13				
061 EMERGENCY	483		30		3,773		
062 OBSERVATION BEDS (NON-DIS							
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	4,469	47,380	219	21,430	14,257		
NONREIMBURS COST CENTERS							
100 FITNESS CENTER							
100 01 MEDICAL OFFICE BUILDING							24
101 CROSS FOOT ADJUSTMENTS							24
102 NEGATIVE COST CENTER							24
103 TOTAL	4,469	47,380	219	21,430	14,257		24

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	25	26	27
GENERAL SERVICE COST CNTR			
003 NEW CAP REL COSTS-BLDG &			
003 01 NEW CAP REL COSTS-IMPROVE			
004 NEW CAP REL COSTS-MVBLE E			
005 EMPLOYEE BENEFITS			
006 01 NONPATIENT TELEPHONES			
006 02 DATA PROCESSING			
006 03 PURCHASING RECEIVING AND			
006 04 ADMITTING			
006 05 CASHIERING/ACCOUNTS RECEI			
006 06 ADMINISTRATIVE AND GENERA			
008 OPERATION OF PLANT			
009 LAUNDRY & LINEN SERVICE			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATION			
017 MEDICAL RECORDS & LIBRARY			
018 SOCIAL SERVICE			
024 PARAMED ED PRGM-(SPECIFY)			
INPAT ROUTINE SRVC CNTRS			
025 ADULTS & PEDIATRICS	170,052		170,052
026 INTENSIVE CARE UNIT	22,848		22,848
027 CORONARY CARE UNIT			
028 BURN INTENSIVE CARE UNIT			
029 SURGICAL INTENSIVE CARE U			
033 NURSERY	10,893		10,893
ANCILLARY SRVC COST CNTRS			
037 OPERATING ROOM	141,276		141,276
038 RECOVERY ROOM	7,990		7,990
038 01 O/P TREATMENT ROOM	22,659		22,659
039 DELIVERY ROOM & LABOR ROO	13,600		13,600
041 RADIOLOGY-DIAGNOSTIC	419,613		419,613
043 RADIOISOTOPE	2,262		2,262
044 LABORATORY	67,798		67,798
046 WHOLE BLOOD & PACKED RED	238		238
049 RESPIRATORY THERAPY	31,562		31,562
050 PHYSICAL THERAPY	51,124		51,124
051 OCCUPATIONAL THERAPY	20,541		20,541
052 SPEECH PATHOLOGY	3,003		3,003
053 ELECTROCARDIOLOGY	37,845		37,845
054 ELECTROENCEPHALOGRAPHY	4		4
055 MEDICAL SUPPLIES CHARGED	7,379		7,379
056 DRUGS CHARGED TO PATIENTS	102,224		102,224
OUTPAT SERVICE COST CNTRS			
060 CLINIC	568		568
060 01 PHYSICIANS PRACTICES	29,814		29,814
061 EMERGENCY	77,303		77,303
062 OBSERVATION BEDS (NON-DIS			
SPEC PURPOSE COST CENTERS			
095 SUBTOTALS	1,240,596		1,240,596
NONREIMBURS COST CENTERS			
100 FITNESS CENTER			
100 01 MEDICAL OFFICE BUILDING	55,279		55,279
101 CROSS FOOT ADJUSTMENTS	24		24
102 NEGATIVE COST CENTER			
103 TOTAL	1,295,899		1,295,899

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	NONPATIENT TE	DATA PROCESSI
	OSTS-BLDG &	OSTS-IMPROVE	OSTS-MVBLE E	FITS	LEPHONES	NG
	(SQ FT	(SQ FT	(EQUIP	(	(PHONES	(DEVICES
	)	)	DEPRN	GROSS	)	)
	3	3.01	4	SALARIES	6.01	6.02
GENERAL SERVICE COST						
003 NEW CAP REL COSTS-BLD	89,507					
003 01 NEW CAP REL COSTS-IMP		89,507				
004 NEW CAP REL COSTS-MVB			313,827			
005 EMPLOYEE BENEFITS				8,904,829		
006 01 NONPATIENT TELEPHONES	104	104	8,296		277	
006 02 DATA PROCESSING	203	203	5,288		3	144
006 03 PURCHASING RECEIVING	633	633	646		2	1
006 04 ADMITTING	878	878	237	336,905	6	5
006 05 CASHIERING/ACCOUNTS R	298	298		41,081	6	3
006 06 ADMINISTRATIVE AND GE	1,674	1,674	20,715	680,594	22	26
008 OPERATION OF PLANT	21,634	21,634	9,497	327,476	22	3
009 LAUNDRY & LINEN SERVI	403	403	518			
010 HOUSEKEEPING	392	392	1,128	175,168	1	1
011 DIETARY	4,384	4,384	16,767	192,915	6	3
012 CAFETERIA				82,447		
014 NURSING ADMINISTRATIO	1,167	1,167	11,419	499,677	3	4
017 MEDICAL RECORDS & LIB	875	875	1,737	191,171	9	10
018 SOCIAL SERVICE						
024 PARAMED ED PRGM-(SPEC				8,383		
INPAT ROUTINE SRVC CN						
025 ADULTS & PEDIATRICS	13,021	13,021	19,732	1,419,559	84	14
026 INTENSIVE CARE UNIT	410	410	12,217	359,377	5	
027 CORONARY CARE UNIT						
028 BURN INTENSIVE CARE U						
029 SURGICAL INTENSIVE CA						
033 NURSERY	902	902	3,629	85,999	1	
ANCILLARY SRVC COST C						
037 OPERATING ROOM	2,846	2,846	71,388	342,278	7	5
038 RECOVERY ROOM	301	301	3,920	67,332	2	
038 01 O/P TREATMENT ROOM	1,608	1,608	2,410	139,280	3	1
039 DELIVERY ROOM & LABOR	655	655	8,139	171,859	1	
041 RADIOLOGY-DIAGNOSTIC	5,915	5,915	30,037	1,329,709	15	13
043 RADIOISOTOPE	263	263			1	
044 LABORATORY	1,570	1,570			6	5
046 WHOLE BLOOD & PACKED						
049 RESPIRATORY THERAPY	1,029	1,029	11,314	294,484	6	5
050 PHYSICAL THERAPY	3,379	3,379	24,640	257,486	12	10
051 OCCUPATIONAL THERAPY	2,842	2,842	551	88,206	8	
052 SPEECH PATHOLOGY	384	384		23,974	1	5
053 ELECTROCARDIOLOGY	322	322	6,104	90,221	3	
054 ELECTROENCEPHALOGRAPH						
055 MEDICAL SUPPLIES CHAR	1,016	1,016	55		2	
056 DRUGS CHARGED TO PATI	1,014	1,014	7,101	341,982	5	4
OUTPUT SERVICE COST C						
060 CLINIC	80	80		10,655		
060 01 PHYSICIANS PRACTICES	3,434	3,434	977	437,059	16	13
061 EMERGENCY	5,745	5,745	26,186	909,552	19	13
062 OBSERVATION BEDS (NON						
SPEC PURPOSE COST CEN						
095 SUBTOTALS	79,381	79,381	304,648	8,904,829	277	144
NONREIMBURS COST CENT						
100 FITNESS CENTER						
100 01 MEDICAL OFFICE BUILDI	10,126	10,126	9,179			
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	195,691	209,657	318,463	1,965,544	51,692	440,723
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	2.186321		1.014772		186.613718	
(WRKSHT B, PT I)		2.342353		.220728		3,060.576389
105 COST TO BE ALLOCATED						
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED					8,890	6,381
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER					32.093863	
(WRKSHT B, PT III)						44.312500

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	PURCHASING RECEIVING AND	ADMITTING	CASHIERING/AC COUNTS RECEI	ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	(REQUISITION)	(TOTAL REVENUE)	(TOTAL REVENUE)	RECONCILIATION	(ACCUM. COST)	(SQ FT)	(LINEN)
	6.03	6.04	6.05	6a.06	6.06	8	9
GENERAL SERVICE COST							
003 NEW CAP REL COSTS-BLD							
003 01 NEW CAP REL COSTS-IMP							
004 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING RECEIVING	275,347						
006 04 ADMITTING	1,083	49,515,924	49,515,924				
006 05 CASHIERING/ACCOUNTS R	143						
006 06 ADMINISTRATIVE AND GE	893			-1,976,621	17,061,421		
008 OPERATION OF PLANT	379				918,231	53,957	
009 LAUNDRY & LINEN SERVI					42,459	403	149,899
010 HOUSEKEEPING	2,263				289,893	392	3,099
011 DIETARY	558				353,522	4,384	
012 CAFETERIA					113,591		
014 NURSING ADMINISTRATIO	10				770,796	1,167	
017 MEDICAL RECORDS & LIB	1,080				336,136	875	
018 SOCIAL SERVICE							
024 PARAMED ED PRGM-(SPEC					12,510		
INPAT ROUTINE SRVC CN							
025 ADULTS & PEDIATRICS	14,524	2,994,184	2,994,184		2,268,887	13,021	54,571
026 INTENSIVE CARE UNIT	2,712	546,040	546,040		524,193	410	
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE U							
029 SURGICAL INTENSIVE CA							
033 NURSERY	1,780	207,179	207,179		136,296	902	
ANCILLARY SRVC COST C							
037 OPERATING ROOM	207,641	4,039,866	4,039,866		1,102,941	2,846	18,064
038 RECOVERY ROOM		350,074	350,074		104,953	301	
038 01 O/P TREATMENT ROOM	1,370	183,464	183,464		218,661	1,608	
039 DELIVERY ROOM & LABOR	4,125	603,464	603,464		268,166	655	
041 RADIOLOGY-DIAGNOSTIC	7,808	11,351,863	11,351,863		2,271,177	5,915	13,657
043 RADIOISOTOPE	109	627,817	627,817		193,387	263	196
044 LABORATORY		7,873,698	7,873,698		1,352,248	1,570	
046 WHOLE BLOOD & PACKED		119,371	119,371		114,563		
049 RESPIRATORY THERAPY	10,278	713,189	713,189		501,782	1,029	
050 PHYSICAL THERAPY	1,547	1,289,335	1,289,335		503,174	3,379	23,274
051 OCCUPATIONAL THERAPY		324,263	324,263		152,190	2,842	
052 SPEECH PATHOLOGY		108,622	108,622		59,533	384	
053 ELECTROCARDIOLOGY	616	1,693,226	1,693,226		222,282	322	6,231
054 ELECTROENCEPHALOGRAPH		7,149	7,149		222		
055 MEDICAL SUPPLIES CHAR	178	265,730	265,730		87,117	1,016	
056 DRUGS CHARGED TO PATI	630	6,734,638	6,734,638		1,277,246	1,014	
OUTPUT SERVICE COST C							
060 CLINIC		19,488	19,488		14,917	80	
060 01 PHYSICIANS PRACTICES	1,446	687,697	687,697		728,236	3,434	
061 EMERGENCY	14,174	8,775,567	8,775,567		2,066,939	5,745	30,807
062 OBSERVATION BEDS (NON							
SPEC PURPOSE COST CEN							
095 SUBTOTALS	275,347	49,515,924	49,515,924	-1,976,621	17,006,248	53,957	149,899
NONREIMBURS COST CENT							
100 FITNESS CENTER							
100 01 MEDICAL OFFICE BUILDI					55,173		
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	135,837	479,651	836,673		1,976,621	1,024,611	55,031
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER		.009687				18.989399	
(WRKSHT B, PT I)	.493330		.016897		.115853		.367121
105 COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
(WRKSHT B, PT II)							
107 COST TO BE ALLOCATED	3,631	5,472	1,678		32,912	112,331	3,272
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER		.000111				2.081861	
(WRKSHT B, PT III)	.013187		.000034		.001929		.021828

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN	MEDICAL RECOR	SOCIAL SERVIC	PARAMED ED PR
	(SQ FT )	(DIETARY )	(FTE )	(TIME )SPENT	(USER )REVENUE	(REFERRALS )	(PARAMED )RADLGY )
	10	11	12	14	17	18	24
GENERAL SERVICE COST							
003 NEW CAP REL COSTS-BLD							
003 01 NEW CAP REL COSTS-IMP							
004 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 01 NONPATIENT TELEPHONES							
006 02 DATA PROCESSING							
006 03 PURCHASING RECEIVING							
006 04 ADMITTING							
006 05 CASHIERING/ACCOUNTS R							
006 06 ADMINISTRATIVE AND GE							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVI							
010 HOUSEKEEPING	53,162						
011 DIETARY	4,384	10,783					
012 CAFETERIA			1,184				
014 NURSING ADMINISTRATIO	1,167		65	440			
017 MEDICAL RECORDS & LIB	875		57		33,187,485		
018 SOCIAL SERVICE							
024 PARAMED ED PRGM-(SPEC							100
INPAT ROUTINE SRVC CN							
025 ADULTS & PEDIATRICS	13,021	7,972	316	316	2,994,184		
026 INTENSIVE CARE UNIT	410	818	53	53	546,040		
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE U							
029 SURGICAL INTENSIVE CA							
033 NURSERY	902		15	15	207,179		
ANCILLARY SRVC COST C							
037 OPERATING ROOM	2,846		62	25	4,039,866		
038 RECOVERY ROOM	301		10	31	350,074		
038 01 O/P TREATMENT ROOM	1,608	1,993	25		183,464		
039 DELIVERY ROOM & LABOR	655		31		603,464		
041 RADIOLOGY-DIAGNOSTIC	5,915		137		11,351,863		
043 RADIOISOTOPE	263						
044 LABORATORY	1,570						
046 WHOLE BLOOD & PACKED							
049 RESPIRATORY THERAPY	1,029		45		713,189		
050 PHYSICAL THERAPY	3,379		48		1,289,335		100
051 OCCUPATIONAL THERAPY	2,842		16		324,263		
052 SPEECH PATHOLOGY	384		3		108,622		
053 ELECTROCARDIOLOGY	322		15		1,693,226		
054 ELECTROENCEPHALOGRAPH					7,149		
055 MEDICAL SUPPLIES CHAR	1,016						
056 DRUGS CHARGED TO PATI	1,014		50				
OUTPUT SERVICE COST C							
060 CLINIC	80		2				
060 01 PHYSICIANS PRACTICES	3,434		70				
061 EMERGENCY	5,745		164		8,775,567		
062 OBSERVATION BEDS (NON							
SPEC PURPOSE COST CEN							
095 SUBTOTALS	53,162	10,783	1,184	440	33,187,485		100
NONREIMBURS COST CENT							
100 FITNESS CENTER							
100 01 MEDICAL OFFICE BUILDI							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	332,060	505,112	126,751	896,503	403,261		13,959
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER		46.843365		2,037.506818			
(WRKSHT B, PT I)	6.246191		107.053209		.012151		139.590000
105 COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
(WRKSHT B, PT II)							
107 COST TO BE ALLOCATED	4,469	47,380	219	21,430	14,257		24
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER		4.393953		48.704545			
(WRKSHT B, PT III)	.084064		.184966		.000430		.240000

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 1/29/2009  
 I 15-1326 I FROM 9/ 1/2007 I WORKSHEET C  
 I I TO 8/31/2008 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
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	3,967,865		3,967,865		
26	INTENSIVE CARE UNIT	753,884		753,884		
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
33	NURSERY	209,534		209,534		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,415,836		1,415,836		
38	RECOVERY ROOM	193,196		193,196		
38 01	O/P TREATMENT ROOM	382,837		382,837		
39	DELIVERY ROOM & LABOR ROO	326,415		326,415		
41	RADIOLOGY-DIAGNOSTIC	2,841,190		2,841,190		
43	RADIOISOTOPE	222,500		222,500		
44	LABORATORY	1,548,530		1,548,530		
46	WHOLE BLOOD & PACKED RED	127,835		127,835		
49	RESPIRATORY THERAPY	599,365		599,365		
50	PHYSICAL THERAPY	690,048		690,048		
51	OCCUPATIONAL THERAPY	247,195		247,195		
52	SPEECH PATHOLOGY	77,762		77,762		
53	ELECTROCARDIOLOGY	280,628		280,628		
54	ELECTROENCEPHALOGRAPHY	335		335		
55	MEDICAL SUPPLIES CHARGED	122,849		122,849		
56	DRUGS CHARGED TO PATIENTS	1,456,161		1,456,161		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	18,878		18,878		
60 01	PHYSICIANS PRACTICES	906,757		906,757		
61	EMERGENCY	2,586,877		2,586,877		
62	OBSERVATION BEDS (NON-DIS	920,518		920,518		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	19,896,995		19,896,995		
102	LESS OBSERVATION BEDS	920,518		920,518		
103	TOTAL	18,976,477		18,976,477		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 1/29/2009  
 I 15-1326 I FROM 9/ 1/2007 I WORKSHEET C  
 I I TO 8/31/2008 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	2,303,095		2,303,095			
26	INTENSIVE CARE UNIT	546,040		546,040			
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY	207,179		207,179			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,393,777	2,646,089	4,039,866	.350466	.350466	
38	RECOVERY ROOM	131,319	218,755	350,074	.551872	.551872	
38 01	O/P TREATMENT ROOM	779	182,685	183,464	2.086715	2.086715	
39	DELIVERY ROOM & LABOR ROO	350,295	253,169	603,464	.540902	.540902	
41	RADIOLOGY-DIAGNOSTIC	1,181,309	10,170,554	11,351,863	.250284	.250284	
43	RADIOISOTOPE	31,636	596,181	627,817	.354403	.354403	
44	LABORATORY	1,451,789	6,421,909	7,873,698	.196671	.196671	
46	WHOLE BLOOD & PACKED RED	62,076	57,295	119,371	1.070905	1.070905	
49	RESPIRATORY THERAPY	514,293	198,896	713,189	.840401	.840401	
50	PHYSICAL THERAPY	157,989	1,131,346	1,289,335	.535197	.535197	
51	OCCUPATIONAL THERAPY	41,329	282,934	324,263	.762329	.762329	
52	SPEECH PATHOLOGY	9,535	99,087	108,622	.715895	.715895	
53	ELECTROCARDIOLOGY	401,628	1,291,598	1,693,226	.165736	.165736	
54	ELECTROENCEPHALOGRAPHY	4,832	2,317	7,149	.046860	.046860	
55	MEDICAL SUPPLIES CHARGED	199,943	65,787	265,730	.462308	.462308	
56	DRUGS CHARGED TO PATIENTS	3,002,650	3,731,988	6,734,638	.216220	.216220	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		19,488	19,488	.968699	.968699	
60 01	PHYSICIANS PRACTICES		687,697	687,697	1.318541	1.318541	
61	EMERGENCY	375,353	8,400,214	8,775,567	.294782	.294782	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		691,089	691,089	1.331982	1.331982	
101	SUBTOTAL	12,366,846	37,149,078	49,515,924			
102	LESS OBSERVATION BEDS						
103	TOTAL	12,366,846	37,149,078	49,515,924			

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO:  
I 15-1326  
T

I PERIOD:  
I FROM 9/ 1/2007  
I TO 8/31/2008

I PREPARED 1/29/2009  
I WORKSHEET C  
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
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	3,967,865		3,967,865		
26	INTENSIVE CARE UNIT	753,884		753,884		
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
33	NURSERY	209,534		209,534		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,415,836		1,415,836		
38	RECOVERY ROOM	193,196		193,196		
38 01	O/P TREATMENT ROOM	382,837		382,837		
39	DELIVERY ROOM & LABOR ROD	326,415		326,415		
41	RADIOLOGY-DIAGNOSTIC	2,841,190		2,841,190		
43	RADIOISOTOPE	222,500		222,500		
44	LABORATORY	1,548,530		1,548,530		
46	WHOLE BLOOD & PACKED RED	127,835		127,835		
49	RESPIRATORY THERAPY	599,365		599,365		
50	PHYSICAL THERAPY	690,048		690,048		
51	OCCUPATIONAL THERAPY	247,195		247,195		
52	SPEECH PATHOLOGY	77,762		77,762		
53	ELECTROCARDIOLOGY	280,628		280,628		
54	ELECTROENCEPHALOGRAPHY	335		335		
55	MEDICAL SUPPLIES CHARGED	122,849		122,849		
56	DRUGS CHARGED TO PATIENTS	1,456,161		1,456,161		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	18,878		18,878		
60 01	PHYSICIANS PRACTICES	906,757		906,757		
61	EMERGENCY	2,586,877		2,586,877		
62	OBSERVATION BEDS (NON-DIS	920,518		920,518		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	19,896,995		19,896,995		
102	LESS OBSERVATION BEDS	920,518		920,518		
103	TOTAL	18,976,477		18,976,477		

COMPUTATION OF RATIO OF COSTS TO CHARGES  
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,303,095		2,303,095			
26	INTENSIVE CARE UNIT	546,040		546,040			
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
33	NURSERY	207,179		207,179			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,393,777	2,646,089	4,039,866	.350466	.350466	
38	RECOVERY ROOM	131,319	218,755	350,074	.551872	.551872	
38	01 O/P TREATMENT ROOM	779	182,685	183,464	2.086715	2.086715	
39	DELIVERY ROOM & LABOR ROO	350,295	253,169	603,464	.540902	.540902	
41	RADIOLOGY-DIAGNOSTIC	1,181,309	10,170,554	11,351,863	.250284	.250284	
43	RADIOISOTOPE	31,636	596,181	627,817	.354403	.354403	
44	LABORATORY	1,451,789	6,421,909	7,873,698	.196671	.196671	
46	WHOLE BLOOD & PACKED RED	62,076	57,295	119,371	1.070905	1.070905	
49	RESPIRATORY THERAPY	514,293	198,896	713,189	.840401	.840401	
50	PHYSICAL THERAPY	157,989	1,131,346	1,289,335	.535197	.535197	
51	OCCUPATIONAL THERAPY	41,329	282,934	324,263	.762329	.762329	
52	SPEECH PATHOLOGY	9,535	99,087	108,622	.715895	.715895	
53	ELECTROCARDIOLOGY	401,628	1,291,598	1,693,226	.165736	.165736	
54	ELECTROENCEPHALOGRAPHY	4,832	2,317	7,149	.046860	.046860	
55	MEDICAL SUPPLIES CHARGED	199,943	65,787	265,730	.462308	.462308	
56	DRUGS CHARGED TO PATIENTS	3,002,650	3,731,988	6,734,638	.216220	.216220	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		19,488	19,488	.968699	.968699	
60	01 PHYSICIANS PRACTICES		687,697	687,697	1.318541	1.318541	
61	EMERGENCY	375,353	8,400,214	8,775,567	.294782	.294782	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		691,089	691,089	1.331982	1.331982	
101	SUBTOTAL	12,366,846	37,149,078	49,515,924			
102	LESS OBSERVATION BEDS						
103	TOTAL	12,366,846	37,149,078	49,515,924			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST	CAPITAL COST	OPERATING	CAPITAL	OPERATING COST	COST NET OF
		WKST B, PT I COL. 27 1	WKST B PT II & III, COL. 27 2	COST NET OF CAPITAL COST 3	REDUCTION 4	REDUCTION AMOUNT 5	CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,415,836	141,276	1,274,560			1,415,836
38	RECOVERY ROOM	193,196	7,990	185,206			193,196
38 01	O/P TREATMENT ROOM	382,837	22,659	360,178			382,837
39	DELIVERY ROOM & LABOR ROO	326,415	13,600	312,815			326,415
41	RADIOLOGY-DIAGNOSTIC	2,841,190	419,613	2,421,577			2,841,190
43	RADIOISOTOPE	222,500	2,262	220,238			222,500
44	LABORATORY	1,548,530	67,798	1,480,732			1,548,530
46	WHOLE BLOOD & PACKED RED	127,835	238	127,597			127,835
49	RESPIRATORY THERAPY	599,365	31,562	567,803			599,365
50	PHYSICAL THERAPY	690,048	51,124	638,924			690,048
51	OCCUPATIONAL THERAPY	247,195	20,541	226,654			247,195
52	SPEECH PATHOLOGY	77,762	3,003	74,759			77,762
53	ELECTROCARDIOLOGY	280,628	37,845	242,783			280,628
54	ELECTROENCEPHALOGRAPHY	335	4	331			335
55	MEDICAL SUPPLIES CHARGED	122,849	7,379	115,470			122,849
56	DRUGS CHARGED TO PATIENTS	1,456,161	102,224	1,353,937			1,456,161
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	18,878	568	18,310			18,878
60 01	PHYSICIANS PRACTICES	906,757	29,814	876,943			906,757
61	EMERGENCY	2,586,877	77,303	2,509,574			2,586,877
62	OBSERVATION BEDS (NON-DIS	920,518		920,518			920,518
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	14,965,712	1,036,803	13,928,909			14,965,712
102	LESS OBSERVATION BEDS	920,518		920,518			920,518
103	TOTAL	14,045,194	1,036,803	13,008,391			14,045,194

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	4,039,866	.350466	.350466
38	RECOVERY ROOM	350,074	.551872	.551872
38 01	O/P TREATMENT ROOM	183,464	2.086715	2.086715
39	DELIVERY ROOM & LABOR ROO	603,464	.540902	.540902
41	RADIOLOGY-DIAGNOSTIC	11,351,863	.250284	.250284
43	RADIOISOTOPE	627,817	.354403	.354403
44	LABORATORY	7,873,698	.196671	.196671
46	WHOLE BLOOD & PACKED RED	119,371	1.070905	1.070905
49	RESPIRATORY THERAPY	713,189	.840401	.840401
50	PHYSICAL THERAPY	1,289,335	.535197	.535197
51	OCCUPATIONAL THERAPY	324,263	.762329	.762329
52	SPEECH PATHOLOGY	108,622	.715895	.715895
53	ELECTROCARDIOLOGY	1,693,226	.165736	.165736
54	ELECTROENCEPHALOGRAPHY	7,149	.046860	.046860
55	MEDICAL SUPPLIES CHARGED	265,730	.462308	.462308
56	DRUGS CHARGED TO PATIENTS	6,734,638	.216220	.216220
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	19,488	.968699	.968699
60 01	PHYSICIANS PRACTICES	687,697	1.318541	1.318541
61	EMERGENCY	8,775,567	.294782	.294782
62	OBSERVATION BEDS (NON-DIS	691,089	1.331982	1.331982
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	46,459,610		
102	LESS OBSERVATION BEDS	691,089		
103	TOTAL	45,768,521		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST	CAPITAL COST	OPERATING	CAPITAL	OPERATING COST	COST NET OF
		WKST B, PT I COL. 27 1	WKST B PT II & III, COL. 27 2	COST NET OF CAPITAL COST 3	REDUCTION 4	REDUCTION AMOUNT 5	CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,415,836	141,276	1,274,560			1,415,836
38	RECOVERY ROOM	193,196	7,990	185,206			193,196
38 01	O/P TREATMENT ROOM	382,837	22,659	360,178			382,837
39	DELIVERY ROOM & LABOR ROO	326,415	13,600	312,815			326,415
41	RADIOLOGY-DIAGNOSTIC	2,841,190	419,613	2,421,577			2,841,190
43	RADIOISOTOPE	222,500	2,262	220,238			222,500
44	LABORATORY	1,548,530	67,798	1,480,732			1,548,530
46	WHOLE BLOOD & PACKED RED	127,835	238	127,597			127,835
49	RESPIRATORY THERAPY	599,365	31,562	567,803			599,365
50	PHYSICAL THERAPY	690,048	51,124	638,924			690,048
51	OCCUPATIONAL THERAPY	247,195	20,541	226,654			247,195
52	SPEECH PATHOLOGY	77,762	3,003	74,759			77,762
53	ELECTROCARDIOLOGY	280,628	37,845	242,783			280,628
54	ELECTROENCEPHALOGRAPHY	335	4	331			335
55	MEDICAL SUPPLIES CHARGED	122,849	7,379	115,470			122,849
56	DRUGS CHARGED TO PATIENTS	1,456,161	102,224	1,353,937			1,456,161
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	18,878	568	18,310			18,878
60 01	PHYSICIANS PRACTICES	906,757	29,814	876,943			906,757
61	EMERGENCY	2,586,877	77,303	2,509,574			2,586,877
62	OBSERVATION BEDS (NON-DIS	920,518		920,518			920,518
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	14,965,712	1,036,803	13,928,909			14,965,712
102	LESS OBSERVATION BEDS	920,518		920,518			920,518
103	TOTAL	14,045,194	1,036,803	13,008,391			14,045,194

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGR RATIO	I/P PT B COST TO CHRGR RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	4,039,866	.350466	.350466
38	RECOVERY ROOM	350,074	.551872	.551872
38 01	O/P TREATMENT ROOM	183,464	2.086715	2.086715
39	DELIVERY ROOM & LABOR ROO	603,464	.540902	.540902
41	RADIOLOGY-DIAGNOSTIC	11,351,863	.250284	.250284
43	RADIOISOTOPE	627,817	.354403	.354403
44	LABORATORY	7,873,698	.196671	.196671
46	WHOLE BLOOD & PACKED RED	119,371	1.070905	1.070905
49	RESPIRATORY THERAPY	713,189	.840401	.840401
50	PHYSICAL THERAPY	1,289,335	.535197	.535197
51	OCCUPATIONAL THERAPY	324,263	.762329	.762329
52	SPEECH PATHOLOGY	108,622	.715895	.715895
53	ELECTROCARDIOLOGY	1,693,226	.165736	.165736
54	ELECTROENCEPHALOGRAPHY	7,149	.046860	.046860
55	MEDICAL SUPPLIES CHARGED	265,730	.462308	.462308
56	DRUGS CHARGED TO PATIENTS	6,734,638	.216220	.216220
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	19,488	.968699	.968699
60 01	PHYSICIANS PRACTICES	687,697	1.318541	1.318541
61	EMERGENCY	8,775,567	.294782	.294782
62	OBSERVATION BEDS (NON-DIS	691,089	1.331982	1.331982
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	46,459,610		
102	LESS OBSERVATION BEDS	691,089		
103	TOTAL	45,768,521		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: I PERIOD: I PREPARED 1/29/2009  
 I 15-1326 I FROM 9/ 1/2007 I WORKSHEET C  
 I I TO 8/31/2008 I PART III

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	1,415,836	4,039,866			
38	RECOVERY ROOM	193,196	350,074			
38 01	O/P TREATMENT ROOM	382,837	183,464			
39	DELIVERY ROOM & LABOR ROO	326,415	603,464			
41	RADIOLOGY-DIAGNOSTIC	2,841,190	11,351,863			
43	RADIOISOTOPE	222,500	627,817			
44	LABORATORY	1,548,530	7,873,698			
46	WHOLE BLOOD & PACKED RED	127,835	119,371			
49	RESPIRATORY THERAPY	599,365	713,189			
50	PHYSICAL THERAPY	690,048	1,289,335			
51	OCCUPATIONAL THERAPY	247,195	324,263			
52	SPEECH PATHOLOGY	77,762	108,622			
53	ELECTROCARDIOLOGY	280,628	1,693,226			
54	ELECTROENCEPHALOGRAPHY	335	7,149			
55	MEDICAL SUPPLIES CHARGED	122,849	265,730			
56	DRUGS CHARGED TO PATIENTS	1,456,161	6,734,638			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	18,878	19,488			
60 01	PHYSICIANS PRACTICES	906,757	687,697			
61	EMERGENCY	2,586,877	8,775,567			
62	OBSERVATION BEDS (NON-DIS	920,518	691,089			
	OTHER REIMBURS COST CNTRS					
101	TOTAL	14,965,712	46,459,610			

COMPUTATION OF OUTPATIENT COST PER VISIT -  
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 1/29/2009  
I 15-1326 I FROM 9/ 1/2007 I WORKSHEET C  
I I TO 8/31/2008 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
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM	1,415,836		1,415,836	4,039,866			
38	RECOVERY ROOM	193,196		193,196	350,074			
38 01	O/P TREATMENT ROOM	382,837		382,837	183,464			
39	DELIVERY ROOM & LABOR ROO	326,415		326,415	603,464			
41	RADIOLOGY-DIAGNOSTIC	2,841,190	664,140	3,505,330	11,351,863			
43	RADIOISOTOPE	222,500		222,500	627,817			
44	LABORATORY	1,548,530		1,548,530	7,873,698			
46	WHOLE BLOOD & PACKED RED	127,835		127,835	119,371			
49	RESPIRATORY THERAPY	599,365		599,365	713,189			
50	PHYSICAL THERAPY	690,048		690,048	1,289,335			
51	OCCUPATIONAL THERAPY	247,195		247,195	324,263			
52	SPEECH PATHOLOGY	77,762		77,762	108,622			
53	ELECTROCARDIOLOGY	280,628		280,628	1,693,226			
54	ELECTROENCEPHALOGRAPHY	335		335	7,149			
55	MEDICAL SUPPLIES CHARGED	122,849		122,849	265,730			
56	DRUGS CHARGED TO PATIENTS	1,456,161		1,456,161	6,734,638			
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	18,878		18,878	19,488			
60 01	PHYSICIANS PRACTICES	906,757		906,757	687,697			
61	EMERGENCY	2,586,877		2,586,877	8,775,567			
62	OBSERVATION BEDS (NON-DIS	920,518		920,518	691,089			
	OTHER REIMBURS COST CNTRS							
101	TOTAL	14,965,712	664,140	15,629,852	46,459,610			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

TITLE XVIII, PART B HOSPITAL

Cost Center Description	Cost/Charge	Cost/Charge	Cost/Charge	Outpatient	Outpatient
	Ratio (C, Pt I, col. 9)	Ratio (C, Pt I, col. 9)	Ratio (C, Pt II, col. 9)	Ambulatory Surgical Ctr	Radialogy
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.350466		.350466		
38 RECOVERY ROOM	.551872		.551872		
38 01 O/P TREATMENT ROOM	2.086715		2.086715		
39 DELIVERY ROOM & LABOR ROOM	.540902		.540902		
41 RADIOLOGY-DIAGNOSTIC	.250284		.250284		
43 RADIOISOTOPE	.354403		.354403		
44 LABORATORY	.196671		.196671		
46 WHOLE BLOOD & PACKED RED BLOOD CELLS	1.070905		1.070905		
49 RESPIRATORY THERAPY	.840401		.840401		
50 PHYSICAL THERAPY	.535197		.535197		
51 OCCUPATIONAL THERAPY	.762329		.762329		
52 SPEECH PATHOLOGY	.715895		.715895		
53 ELECTROCARDIOLOGY	.165736		.165736		
54 ELECTROENCEPHALOGRAPHY	.046860		.046860		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.462308		.462308		
56 DRUGS CHARGED TO PATIENTS	.216220		.216220		
60 01 OUTPAT SERVICE COST CNTRS	.968699		.968699		
60 CLINIC					
60 01 PHYSICIANS PRACTICES	1.318541		1.318541		
61 EMERGENCY	.294782		.294782		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.331982		1.331982		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		881,096			
38 RECOVERY ROOM		48,488			
38 01 O/P TREATMENT ROOM		112,871			
39 DELIVERY ROOM & LABOR ROOM		3,645			
41 RADIOLOGY-DIAGNOSTIC		3,374,355			
43 RADIOISOTOPE		242,643			
44 LABORATORY		2,516,341			
46 WHOLE BLOOD & PACKED RED BLOOD CELLS		49,088			
49 RESPIRATORY THERAPY		137,521			
50 PHYSICAL THERAPY		406,889			
51 OCCUPATIONAL THERAPY		94,933			
52 SPEECH PATHOLOGY		8,132			
53 ELECTROCARDIOLOGY		618,005			
54 ELECTROENCEPHALOGRAPHY		604			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		8,758			
56 DRUGS CHARGED TO PATIENTS		1,313,922			
60 01 CLINIC		3,115			
60 01 PHYSICIANS PRACTICES					
61 EMERGENCY		2,271,452			
62 OBSERVATION BEDS (NON-DISTINCT PART)		319,227			
101 SUBTOTAL		12,411,085			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		12,411,085			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

All Other Hospital I/P Hospital I/P  
 Part B Charges Part B Costs

Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	308,794		
38 RECOVERY ROOM	26,759		
38 01 O/P TREATMENT ROOM	235,530		
39 DELIVERY ROOM & LABOR ROOM	1,972		
41 RADIOLOGY-DIAGNOSTIC	844,547		
43 RADIOISOTOPE	85,993		
44 LABORATORY	494,891		
46 WHOLE BLOOD & PACKED RED BLOOD CELLS	52,569		
49 RESPIRATORY THERAPY	115,573		
50 PHYSICAL THERAPY	217,766		
51 OCCUPATIONAL THERAPY	72,370		
52 SPEECH PATHOLOGY	5,822		
53 ELECTROCARDIOLOGY	102,426		
54 ELECTROENCEPHALOGRAPHY	28		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,049		
56 DRUGS CHARGED TO PATIENTS	284,096		
60 OUTPAT SERVICE COST CNTRS			
60 CLINIC	3,017		
60 01 PHYSICIANS PRACTICES			
61 EMERGENCY	669,583		
62 OBSERVATION BEDS (NON-DISTINCT PART)	425,205		
101 SUBTOTAL	3,950,990		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	3,950,990		

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B      HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.216220
2	PROGRAM VACCINE CHARGES		5,942
3	PROGRAM COSTS		1,285

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	1/29/2009
I	15-1326	I	FROM 9/ 1/2007	I	WORKSHEET D-1	
I	COMPONENT NO:	I	TO 8/31/2008	I	PART I	
I	15-1326	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)	3,707
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,541
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,541
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	166
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,615
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)	159
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

## SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,967,865
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	177,681
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,790,184

## PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,051,385
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	302,975
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,748,410
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.847622
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	493.76
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	3,790,184

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					1,070.37
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,728,648
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,728,648

	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	753,884	292	2,581.79	178	459,559
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
					1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				

1,133,537  
 3,321,744

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)	170,189
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	170,189
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 1/29/2009  
 I 15-1326 I FROM 9/ 1/2007 I WORKSHEET D-1  
 I COMPONENT NO: I TO 8/31/2008 I PART III  
 I 15-1326 I I

TITLE XVIII PART A

HOSPITAL

OTHER

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS 860
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 1,070.37
- 85 OBSERVATION BED COST 920,518

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,299,711	
26	INTENSIVE CARE UNIT		332,860	
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.350466	622,837	218,283
38	RECOVERY ROOM	.551872	32,012	17,667
38	01 O/P TREATMENT ROOM	2.086715		
39	DELIVERY ROOM & LABOR ROOM	.540902		
41	RADIOLOGY-DIAGNOSTIC	.250284	504,387	126,240
43	RADIOISOTOPE	.354403	16,904	5,991
44	LABORATORY	.196671	678,718	133,484
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.070905	46,864	50,187
49	RESPIRATORY THERAPY	.840401	109,742	92,227
50	PHYSICAL THERAPY	.535197	113,152	60,559
51	OCCUPATIONAL THERAPY	.762329	24,526	18,697
52	SPEECH PATHOLOGY	.715895	7,825	5,602
53	ELECTROCARDIOLOGY	.165736	289,950	48,055
54	ELECTROENCEPHALOGRAPHY	.046860	604	28
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.462308	80,503	37,217
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.216220	1,476,736	319,300
60	CLINIC	.968699		
60	01 PHYSICIANS PRACTICES	1.318541		
61	EMERGENCY	.294782		
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	1.331982		
101	TOTAL		4,004,760	1,133,537
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		4,004,760	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 1/29/2009  
 I 15-1326 I FROM 9/ 1/2007 I WORKSHEET D-4  
 I COMPONENT NO: I TO 8/31/2008 I  
 I 15-2326 I 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
25	INPAT ROUTINE SRVC CNTRS			
	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.350466	4,942	1,732
38	RECOVERY ROOM	.551872		
38 01	O/P TREATMENT ROOM	2.086715		
39	DELIVERY ROOM & LABOR ROOM	.540902		
41	RADIOLOGY-DIAGNOSTIC	.250284	4,587	1,148
43	RADIOISOTOPE	.354403		
44	LABORATORY	.196671	16,418	3,229
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.070905		
49	RESPIRATORY THERAPY	.840401	7,712	6,481
50	PHYSICAL THERAPY	.535197	25,174	13,473
51	OCCUPATIONAL THERAPY	.762329	11,926	9,092
52	SPEECH PATHOLOGY	.715895	1,175	841
53	ELECTROCARDIOLOGY	.165736	2,987	495
54	ELECTROENCEPHALOGRAPHY	.046860		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.462308	8,561	3,958
56	DRUGS CHARGED TO PATIENTS	.216220	97,785	21,143
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.968699		
60 01	PHYSICIANS PRACTICES	1.318541		
61	EMERGENCY	.294782		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.331982		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		181,267	61,592
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		181,267	

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		857,500	
26	INTENSIVE CARE UNIT		196,350	
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.350466	481,236	168,657
38	RECOVERY ROOM	.551872	63,744	35,179
38 01	O/P TREATMENT ROOM	2.086715	779	1,626
39	DELIVERY ROOM & LABOR ROOM	.540902	241,248	130,492
41	RADIOLOGY-DIAGNOSTIC	.250284	359,882	90,073
43	RADIOISOTOPE	.354403	6,169	2,186
44	LABORATORY	.196671	506,103	99,536
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	1.070905	14,911	15,968
49	RESPIRATORY THERAPY	.840401	67,927	57,086
50	PHYSICAL THERAPY	.535197	19,663	10,524
51	OCCUPATIONAL THERAPY	.762329	4,877	3,718
52	SPEECH PATHOLOGY	.715895	535	383
53	ELECTROCARDIOLOGY	.165736	106,045	17,575
54	ELECTROENCEPHALOGRAPHY	.046860	604	28
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.462308	110,879	51,260
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.216220	1,088,293	235,311
60	CLINIC	.968699		
60 01	PHYSICIANS PRACTICES	1.318541		
61	EMERGENCY	.294782	162,557	47,919
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	1.331982		
101	TOTAL		3,235,452	967,521
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,235,452	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 3,952,275  
 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) 3,952,275

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES  
 6 ANCILLARY SERVICE CHARGES  
 7 INTERNS AND RESIDENTS SERVICE CHARGES  
 8 ORGAN ACQUISITION CHARGES  
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.  
 10 TOTAL REASONABLE CHARGES  
 CUSTOMARY CHARGES  
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS  
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).  
 13 RATIO OF LINE 11 TO LINE 12  
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)  
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST  
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES  
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 3,991,798  
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 40,631  
 18.01 CAH ACTUAL BILLED COINSURANCE 1,972,166  
 LINE 17.01 (SEE INSTRUCTIONS)  
 19 SUBTOTAL (SEE INSTRUCTIONS) 1,979,001  
 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)  
 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS  
 22 ESRD DIRECT MEDICAL EDUCATION COSTS  
 23 SUBTOTAL 1,979,001  
 24 PRIMARY PAYER PAYMENTS 44  
 25 SUBTOTAL 1,978,957

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD  
 27 BAD DEBTS (SEE INSTRUCTIONS) 530,215  
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 530,215  
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 421,236  
 28 SUBTOTAL 2,509,172  
 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 2,509,172  
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)  
 34 INTERIM PAYMENTS 1,957,884  
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)  
 35 BALANCE DUE PROVIDER/PROGRAM 551,288  
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) 476,835  
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

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		2,474,686		2,127,305
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	4/ 1/2008	61,601	
ADJUSTMENTS TO PROVIDER	.02			
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROGRAM	.50		4/ 1/2008	169,421
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99		61,601	-169,421
4 TOTAL INTERIM PAYMENTS		2,536,287		1,957,884
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
SUBTOTAL	.99		NONE	NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER	.01			
SETTLEMENT TO PROGRAM	.02			
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

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

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

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

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		208,677		
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	4/ 1/2008	800	
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		800	NONE
4 TOTAL INTERIM PAYMENTS			209,477	
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
SUBTOTAL	.99		NONE	NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER	.01			
SETTLEMENT TO PROGRAM	.02			
7 TOTAL MEDICARE PROGRAM LIABILITY				

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

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)	171,891	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	62,208	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	159	159
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	234,099	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	234,099	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	234,099	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		
14	80% OF PART B COSTS		
15	SUBTOTAL	234,099	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	234,099	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	209,477	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	24,622	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	3,321,744
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,321,744
5	PRIMARY PAYER PAYMENTS	1,643
6	TOTAL COST FOR CAH (SEE INSTRUCTIONS)	3,353,302
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	3,353,302
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	464,513
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,888,789
23	COINSURANCE	1,792
24	SUBTOTAL	2,886,997
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	127,040
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	127,040
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	93,243
26	SUBTOTAL	3,014,037
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	3,014,037
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,536,287
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	477,750
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 1/29/2009  
 I 15-1326 I FROM 9/ 1/2007 I  
 I I TO 8/31/2008 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS				
2 TEMPORARY INVESTMENTS				
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE				
5 OTHER RECEIVABLES				
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7 INVENTORY				
8 PREPAID EXPENSES				
9 OTHER CURRENT ASSETS				
10 DUE FROM OTHER FUNDS				
11 TOTAL CURRENT ASSETS				
FIXED ASSETS				
12 LAND				
12.01				
13 LAND IMPROVEMENTS				
13.01 LESS ACCUMULATED DEPRECIATION				
14 BUILDINGS				
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				
OTHER ASSETS				
22 INVESTMENTS				
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS				
26 TOTAL OTHER ASSETS	1,458,972			
27 TOTAL ASSETS	1,458,972			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE				
29 SALARIES, WAGES & FEES PAYABLE				
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				
36 TOTAL CURRENT LIABILITIES				
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES				
43 TOTAL LIABILITIES				
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	1,458,972			
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	1,458,972			
52 TOTAL LIABILITIES AND FUND BALANCES	1,458,972			

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD				
2 NET INCOME (LOSS)		1,458,972		
3 TOTAL		1,458,972		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		1,458,972		
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		1,458,972		

	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				

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	2,430,488		2,430,488
4 00 SWING BED - SNF	77,150		77,150
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,507,638		2,507,638
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	546,040		546,040
11 00 CORONARY CARE UNIT			
12 00 BURN INTENSIVE CARE UNIT			
13 00 SURGICAL INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	546,040		546,040
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,053,678		3,053,678
17 00 ANCILLARY SERVICES	9,774,579		9,774,579
18 00 OUTPATIENT SERVICES		38,992,125	38,992,125
24 00			
25 00 TOTAL PATIENT REVENUES	12,828,257	38,992,125	51,820,382

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		18,006,494	
ADD (SPECIFY)			
27 00 BENEFITS	1,691,879		
28 00 PHOENIX ALLOCATION	215,575		
29 00 BAD DEBT	2,148,853		
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		4,056,307	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		22,062,801	

DESCRIPTION

1	TOTAL PATIENT REVENUES	51,820,382
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	28,912,418
3	NET PATIENT REVENUES	22,907,964
4	LESS: TOTAL OPERATING EXPENSES	22,062,801
5	NET INCOME FROM SERVICE TO PATIENTS	845,163
	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	592,124
24.01	NON OPERATING REVENUE	32,318
25	TOTAL OTHER INCOME	624,442
26	TOTAL	1,469,605
	OTHER EXPENSES	
27	LOSS ON DISPOSAL	10,633
28		
29		
30	TOTAL OTHER EXPENSES	10,633
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,458,972