

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 reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/28/2012 4:39 pm
--	----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/28/2012 Time: 4:39 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - 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 IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE 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 FRANKLIN HOSPITAL for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and 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 identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-24,702	-157,612	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	-3,853	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		-49,474		0	10.00
10.01 RURAL HEALTH CLINIC (RHC) II	0		2,974		0	10.01
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-28,555	-204,112	0	0	200.00

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 and review the information collection is estimated 673 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 the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 141321		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 4:07 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 201 BAILEY LANE			PO Box:							1.00
2.00	City: BENTON			State: IL		Zip Code: 62812		County: FRANKLIN			2.00
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		FRANKLIN HOSPITAL	141321	14999	1	08/01/2002	N	0	N	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		FRANKLIN HOSPITAL SWING BED	14Z321	14999		08/01/2002	N	0	N	7.00
8.00	Swing Beds - NF							N		N	8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		FRANKLIN RHC	143469	14999		07/06/2005	N	0	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1		WEST FRANKFORT RHC	148510	14999		04/23/2010	N	0	N	15.01
16.00	Hospital-Based Health Clinic - FOHC										16.00
17.00	Hospital-Based (CMHC) 1										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2011	06/30/2012		20.00	
21.00	Type of Control (see instructions)						9		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						2		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00		
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						2		26.00		
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00		
							Beginning:	Ending:			
							1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.						0		37.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 4:07 pm		
		Beginning:	Ending:			
		1.00	2.00			
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 4:07 pm		
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 4:07 pm		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did 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. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)			N		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
				V	XIX	
				1.00	2.00	
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		N		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 4:07 pm	
			1.00	2.00	3.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
			Premiums	Losses	Insurance
			1.00	2.00	3.00
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	150,860	0	0	118.01
			1.00	2.00	
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
			1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:		
142.00	Street:	PO Box:			
143.00	City:	State:	Zip Code:		
			1.00		
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N	145.00
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141321		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 4:07 pm		
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	157.00		
158.00	SUBPROVIDER					158.00		
159.00	SNF	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00		
161.00	CMHC	N	N	N	N	161.00		
						1.00		
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/28/2012 4:07 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/22/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/28/2012 4:07 pm
---	--	----------------------	---	---

		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544		KWELLEN@BKD.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/22/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGING CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	27,888.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	27,888.00		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	27,888.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.01 RURAL HEALTH CLINIC (RHC)	88.01					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	824	88	1,162		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	120	0	120		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	944	88	1,282		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0	944	88	1,282		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	2,573	4,216	11,564		26.00
26.01 RURAL HEALTH CLINIC (RHC)	0	205	672	1,919		26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	198		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	217	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	131.03	0.00	0	217	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	18.54	0.00			26.00
26.01 RURAL HEALTH CLINIC (RHC)	0.00	4.39	0.00			26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	153.96	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	37	326		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	37	326		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.01 RURAL HEALTH CLINIC (RHC)				26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141321 Component CCN: 143469		Period: From 07/01/2011 To 06/30/2012		Worksheet S-8 Date/Time Prepared: 11/28/2012 4:07 pm	
				Rural Health Clinic (RHC) I		Cost	
				1.00			
1.00	Clinic Address and Identification			201 BAILEY LANE		1.00	
	Street			City		State Zip Code	
				1.00		2.00 3.00	
2.00	City, State, Zip Code, County			BENTON IL		62812 2.00	
				1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00	
				Grant Award		Date	
				1.00		2.00	
		Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00	
7.00	Appalachian Regional Commission			0		7.00	
8.00	Look-Alikes			0		8.00	
9.00	OTHER (SPECIFY)			0		9.00	
				1.00		2.00	
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
		Sunday		Monday			
		from to		from to			
		1.00 2.00		3.00 4.00			
11.00	Facility hours of operations (1)			09:00 21:00		11.00	
		Clinic					
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00	Provider name, CCN number			FRANKLIN RHC		143469 14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable, and the total number of visits in column 5. (see instructions)			N		0 0 0 0 15.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/28/2012 4:07 pm Cost
		Rural Health Clinic (RHC) I		
		County 4.00		
2.00	City, State, Zip Code, County			2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	09:00	21:00	09:00
				21:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/28/2012 4:07 pm		
			Rural Health Clinic (RHC) I	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	09:00	21:00	09:00	21:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/28/2012 4:07 pm Cost
		Rural Health Clinic (RHC) I	

		Saturday			
		from	to		
11.00	Facility hours of operations (1) Clinic	12:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141321 Component CCN: 148510		Period: From 07/01/2011 To 06/30/2012		Worksheet S-8 Date/Time Prepared: 11/28/2012 4:07 pm	
				Rural Health Clinic (RHC) II		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		201 BAILEY LANE				1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		BENTON		IL		62812 2.00	
3.00							
FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
0 3.00							
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
10.00							
Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0 10.00	
				Sunday		Monday	
		from to		from to			
		1.00 2.00		3.00 4.00			
11.00 Facility hours of operations (1)							
11.00 Clinic				09:00		17:00 11.00	
12.00							
Have you received an approval for an exception to the productivity standard?				N		12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00 Provider name, CCN number		WEST FRANKFORT CLINIC		148510		14.00	
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00		N		0		0 15.00	
Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable, and the total number of visits in column 5. (see instructions)							

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141321 Component CCN: 148510	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/28/2012 4:07 pm
			Rural Health Clinic (RHC) II	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County			2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	09:00	17:00	09:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141321 Component CCN: 148510	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/28/2012 4:07 pm		
			Rural Health Clinic (RHC) II	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	09:00	17:00	09:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141321 Component CCN: 148510	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/28/2012 4:07 pm
			Rural Health Clinic (RHC) II	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet S-10 Date/Time Prepared: 11/28/2012 4:07 pm
---	----------------------	---	---

			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.468118	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,929,941	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		6,776,341	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,172,127	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,242,186	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,242,186	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	396,248	0	396,248	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	185,491	0	185,491	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	185,491	0	185,491	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,647,177	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		525,955	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		2,121,222	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		992,982	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,178,473	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,420,659	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 141321 Period: From 07/01/2011 To 06/30/2012 Worksheet A
 Date/Time Prepared: 11/28/2012 4:07 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		209,425	209,425	201,770	411,195	1.00
2.00	00200		295,222	295,222	17,157	312,379	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	58,260	738,391	796,651	1,085	797,736	4.00
5.00	00500	863,766	1,047,549	1,911,315	65,616	1,976,931	5.00
6.00	00600	151,393	164,897	316,290	-333	315,957	6.00
7.00	00700	0	426,881	426,881	7,028	433,909	7.00
8.00	00800	0	76,073	76,073	0	76,073	8.00
9.00	00900	221,530	53,275	274,805	0	274,805	9.00
10.00	01000	262,676	251,240	513,916	-120,256	393,660	10.00
11.00	01100	0	0	0	120,256	120,256	11.00
13.00	01300	360,832	42,716	403,548	0	403,548	13.00
16.00	01600	158,975	57,924	216,899	0	216,899	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	570,465	331,479	901,944	0	901,944	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	620,317	63,051	683,368	-19	683,349	50.00
53.00	05301	0	61,473	61,473	-441	61,032	53.00
54.00	05400	467,634	294,671	762,305	0	762,305	54.00
60.00	06000	368,666	554,841	923,507	0	923,507	60.00
65.00	06500	224,555	127,479	352,034	-4,926	347,108	65.00
66.00	06600	19,699	177,231	196,930	0	196,930	66.00
71.00	07100	65,562	62,153	127,715	5,386	133,101	71.00
73.00	07300	145,808	341,143	486,951	0	486,951	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,255,374	131,598	1,386,972	69,405	1,456,377	88.00
88.01	08801	331,228	48,581	379,809	-75,025	304,784	88.01
90.00	09000	217,857	193,188	411,045	0	411,045	90.00
91.00	09100	575,545	1,404,942	1,980,487	-221	1,980,266	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		286,482	286,482	-286,482	0	113.00
118.00		6,940,142	7,441,905	14,382,047	0	14,382,047	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	59,501	10,682	70,183	0	70,183	192.00
200.00		6,999,643	7,452,587	14,452,230	0	14,452,230	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-7,282	403,913	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	312,379	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-5,756	791,980	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-25,696	1,951,235	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	315,957	6.00
7.00	00700	OPERATION OF PLANT	-95,967	337,942	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,073	8.00
9.00	00900	HOUSEKEEPING	0	274,805	9.00
10.00	01000	DIETARY	-169,706	223,954	10.00
11.00	01100	CAFETERIA	-51,035	69,221	11.00
13.00	01300	NURSING ADMINISTRATION	0	403,548	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,731	209,168	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	901,944	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-415,368	267,981	50.00
53.00	05301	ANESTHESIOLOGY	-47,990	13,042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	762,305	54.00
60.00	06000	LABORATORY	-26,000	897,507	60.00
65.00	06500	RESPIRATORY THERAPY	-51,300	295,808	65.00
66.00	06600	PHYSICAL THERAPY	-10,623	186,307	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	133,101	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,043	484,908	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-229,005	1,227,372	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	-3,712	301,072	88.01
90.00	09000	CLINIC	-36,000	375,045	90.00
91.00	09100	EMERGENCY	-406,276	1,573,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,591,490	12,790,557	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	70,183	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,591,490	12,860,740	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - TO RECLASS DIETARY MEALS					
1.00	CAFETERIA	11.00	61,466	58,790	1.00
	TOTALS		61,466	58,790	
B - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	169,094	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	117,388	2.00
	TOTALS		0	286,482	
C - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	49,833	1.00
	TOTALS		0	49,833	
D - HEALTH INSURANCE					
1.00	EMPLOYEE BENEFITS	4.00	0	1,085	1.00
	TOTALS		0	1,085	
E - RHC PROVIDERS					
1.00	RURAL HEALTH CLINIC	88.00	66,299	3,672	1.00
	TOTALS		66,299	3,672	
F - TELEPHONE EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	7,028	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	7,028	
G - TO RECLASS MSCTP					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,386	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	5,386	
500.00	Grand Total: Increases		127,765	412,276	500.00

RECLASSIFICATIONS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-6

Date/Time Prepared:
11/28/2012 4:07 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - TO RECLASS DIETARY MEALS							
1.00	DIETARY	10.00	61,466	58,790	0		1.00
	TOTALS		61,466	58,790			
B - TO RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	286,482	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	286,482			
C - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	49,833	0		1.00
	TOTALS		0	49,833			
D - HEALTH INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,085	0		1.00
	TOTALS		0	1,085			
E - RHC PROVIDERS							
1.00	RURAL HEALTH CLINIC (RHC)	88.01	66,299	3,672	0		1.00
	TOTALS		66,299	3,672			
F - TELEPHONE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	854	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	333	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	566	0		3.00
4.00	RURAL HEALTH CLINIC (RHC)	88.01	0	5,054	0		4.00
5.00	EMERGENCY	91.00	0	221	0		5.00
	TOTALS		0	7,028			
G - TO RECLASS MSCTP							
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	0	19	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	441	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	4,926	0		4.00
	TOTALS		0	5,386			
500.00	Grand Total: Decreases		127,765	412,276			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/28/2012 4:07 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	18,401	0	0	0	1.00
2.00	Land Improvements	103,779	0	0	0	2.00
3.00	Buildings and Fixtures	4,557,832	0	0	0	3.00
4.00	Building Improvements	4,607,742	0	0	0	4.00
5.00	Fixed Equipment	1,327,198	213,576	0	213,576	5.00
6.00	Movable Equipment	4,841,199	26,005	0	26,005	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,456,151	239,581	0	239,581	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,456,151	239,581	0	239,581	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	209,425	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	295,222	0	0	0	2.00
3.00	Total (sum of lines 1-2)	504,647	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	9,269,353	0	9,269,353	0.655701	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,407,978	1,540,774	4,867,204	0.344299	2.00
3.00	Total (sum of lines 1-2)	15,677,331	1,540,774	14,136,557	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/28/2012 4:07 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	18,401	0		1.00	
2.00	Land Improvements	103,779	0		2.00	
3.00	Buildings and Fixtures	4,557,832	0		3.00	
4.00	Building Improvements	4,607,742	0		4.00	
5.00	Fixed Equipment	1,540,774	0		5.00	
6.00	Movable Equipment	4,867,204	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	15,695,732	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	15,695,732	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	209,425		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	295,222		2.00	
3.00	Total (sum of lines 1-2)	0	504,647		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	32,676	209,425	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	17,157	295,222	0
3.00	Total (sum of lines 1-2)	0	0	49,833	504,647	0

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet A-7 Parts I-III Date/Time Prepared: 11/28/2012 4:07 pm
---	----------------------	---	---

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	161,812	32,676	0	0	403,913	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	17,157	0	0	312,379	2.00
3.00	Total (sum of lines 1-2)	161,812	49,833	0	0	716,292	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-7,282	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)	B	-5,055	ADMINISTRATIVE & GENERAL	5.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-5,741	ADMINISTRATIVE & GENERAL	5.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00 Television and radio service (chapter 21)		0		0.00	8.00
9.00 Parking lot (chapter 21)		0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-970,116			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00 Laundry and linen service		0		0.00	13.00
14.00 Cafeteria-employees and guests	B	-51,035	CAFETERIA	11.00	14.00
15.00 Rental of quarters to employee and others		0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00 Sale of drugs to other than patients	B	-2,043	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00 Sale of medical records and abstracts	B	-7,731	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00 Vending machines		0		0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	-10,623	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00 DIETARY ADJUSTMENT	B	-169,706	DIETARY	10.00	33.00
33.01 CLINIC UTILITIES	B	-95,967	OPERATION OF PLANT	7.00	33.01
33.02 ADVERTISING	A	-7,109	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03 MISCELLANEOUS INCOME	B	-6,535	ADMINISTRATIVE & GENERAL	5.00	33.03
33.04 CASH OVER/SHORT	B	-1,256	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05 NON RHC PHYSICIAN SALARY COSTS	A	-217,280	RURAL HEALTH CLINIC	88.00	33.05
33.06 NON RHC PHYSICIAN SALARY COSTS	A	-3,671	RURAL HEALTH CLINIC (RHC)	88.01	33.06
33.07 NON RHC PHYSICIAN FICA	A	-11,725	RURAL HEALTH CLINIC	88.00	33.07
33.08 NON RHC PHYSICIAN FICA	A	-41	RURAL HEALTH CLINIC (RHC)	88.01	33.08
33.09 NON RHC PHYSICIAN BENEFIT OFFSET	A	-2,423	EMPLOYEE BENEFITS	4.00	33.09
33.10 SURGEON FICA	A	-12,818	OPERATING ROOM	50.00	33.10
33.11 SURGEON BENEFIT OFFSET	A	-3,333	EMPLOYEE BENEFITS	4.00	33.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,591,490			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	DIETARY ADJUSTMENT	0	33.00
33.01	CLINIC UTILITIES	0	33.01
33.02	ADVERTISING	0	33.02
33.03	MISCELLANEOUS INCOME	0	33.03
33.04	CASH OVER/SHORT	0	33.04
33.05	NON RHC PHYSICIAN SALARY COSTS	0	33.05
33.06	NON RHC PHYSICIAN SALARY COSTS	0	33.06
33.07	NON RHC PHYSICIAN FICA	0	33.07
33.08	NON RHC PHYSICIAN FICA	0	33.08
33.09	NON RHC PHYSICIAN BENEFIT OFFSET	0	33.09
33.10	SURGEON FICA	0	33.10
33.11	SURGEON BENEFIT OFFSET	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/28/2012 4:07 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	53.00	ANESTHESIOLOGY	47,990	47,990	1.00
2.00	60.00	LABORATORY	26,000	26,000	2.00
3.00	65.00	RESPIRATORY THERAPY	51,300	51,300	3.00
4.00	90.00	CLINIC	36,000	36,000	4.00
5.00	91.00	EMERGENCY	1,251,036	406,276	5.00
6.00	50.00	OPERATING ROOM	402,550	402,550	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,814,876	970,116	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/28/2012 4:07 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	844,760	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	844,760			0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/28/2012 4:07 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/28/2012 4:07 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	47,990	1.00
2.00	0	26,000	2.00
3.00	0	51,300	3.00
4.00	0	36,000	4.00
5.00	0	406,276	5.00
6.00	0	402,550	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	970,116	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141321		Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2012 4:07 pm	
		Physical Therapy		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					242	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					102	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	761.31	423.63	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.57	54.43	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.29	36.29	27.22			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					55,248	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					23,058	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					78,306	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					78,306	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					78,306	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					8,782	24.00
25.00	Assistants (line 4 times column 3, line 11)					2,776	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					11,558	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,892	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					13,450	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					13,450	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141321				Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2012 4:07 pm	
		Physical Therapy				Cost			
						1.00			
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.57	54.43	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					78,306		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					13,450		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					91,756		63.00	
64.00	Total cost of outside supplier services (from your records)					102,379		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					10,623		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					11,558		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,892		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					13,450		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,892		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					1,892		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141321		Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2012 4:07 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					15	1.00
2.00	Line 1 multiplied by 15 hours per week					225	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					80	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					11	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	101.58	56.17	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.79	51.59	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.40	34.40	25.80			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					6,988	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					2,898	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					9,886	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					9,886	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					62.67	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					14,101	22.00
23.00	Total salary equivalency (see instructions)					14,101	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,752	24.00
25.00	Assistants (line 4 times column 3, line 11)					284	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,036	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					501	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,537	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,537	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141321		Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2012 4:07 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.79	51.59	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					14,101	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					3,537	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					17,638	63.00
64.00	Total cost of outside supplier services (from your records)					13,461	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					3,036	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					501	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					3,537	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					501	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					501	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2012 4:07 pm		
			Speech Pathology	Cost		
			1.00			
PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)			52	1.00	
2.00	Line 1 multiplied by 15 hours per week			780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			328	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00	
7.00	Standard travel expense rate			5.50	7.00	
8.00	Optional travel expense rate per mile			0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees
		1.00	2.00	3.00	4.00	5.00
9.00	Total hours worked	0.00	492.53	0.00	0.00	0.00
10.00	AHSEA (see instructions)	0.00	66.10	0.00	0.00	0.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.05	33.05	0.00		
12.00	Number of travel hours (provider site)	0	0	0		
12.01	Number of travel hours (offsite)	0	0	0		
13.00	Number of miles driven (provider site)	0	0	0		
13.01	Number of miles driven (offsite)	0	0	0		
			1.00			
Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)			32,556	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			32,556	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			32,556	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			66.10	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			51,558	22.00	
23.00	Total salary equivalency (see instructions)			51,558	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)			10,840	24.00	
25.00	Assistants (line 4 times column 3, line 11)			0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			10,840	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			1,804	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			12,644	28.00	
Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)			12,644	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00	
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)			0	36.00	
37.00	Assistants (line 6 times column 3, line 11)			0	37.00	
38.00	Subtotal (sum of lines 36 and 37)			0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00	
Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00	
42.00	Subtotal (sum of lines 40 and 41)			0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)			0	45.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141321				Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/28/2012 4:07 pm	
						Speech Pathology		Cost	
								1.00	
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								0 46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.10	0.00	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
								1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							51,558	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)							12,644	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							64,202	63.00
64.00	Total cost of outside supplier services (from your records)							33,740	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							10,840	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							1,804	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							12,644	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							1,804	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							1,804	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	403,913	403,913			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	312,379		312,379		2.00
4.00 00400	EMPLOYEE BENEFITS	791,980	1,474	0	793,454	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,951,235	40,845	14,083	109,085	2,115,248 5.00
6.00 00600	MAINTENANCE & REPAIRS	315,957	15,804	7,772	18,996	358,529 6.00
7.00 00700	OPERATION OF PLANT	337,942	49,396	3,178	0	390,516 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	76,073	4,343	0	0	80,416 8.00
9.00 00900	HOUSEKEEPING	274,805	1,394	0	27,797	303,996 9.00
10.00 01000	DIETARY	223,954	28,720	1,865	25,247	279,786 10.00
11.00 01100	CAFETERIA	69,221	0	0	7,713	76,934 11.00
13.00 01300	NURSING ADMINISTRATION	403,548	1,966	0	45,276	450,790 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	209,168	6,089	9,795	19,948	245,000 16.00
17.00 01700	SOCIAL SERVICE	0	1,428	0	0	1,428 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	901,944	34,776	125,705	71,581	1,134,006 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	267,981	37,292	45,304	27,325	377,902 50.00
53.00 05301	ANESTHESIOLOGY	13,042	598	88	0	13,728 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	762,305	15,990	65,890	58,678	902,863 54.00
60.00 06000	LABORATORY	897,507	8,818	9,655	46,259	962,239 60.00
65.00 06500	RESPIRATORY THERAPY	295,808	7,862	2,363	28,177	334,210 65.00
66.00 06600	PHYSICAL THERAPY	186,307	7,597	325	2,472	196,701 66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,101	14,662	700	8,227	156,690 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	484,908	6,176	7,360	18,296	516,740 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,227,372	40,772	0	138,575	1,406,719 88.00
88.01 08801	RURAL HEALTH CLINIC (RHC)	301,072	8,785	9,942	32,782	352,581 88.01
90.00 09000	CLINIC	375,045	16,355	8,243	27,336	426,979 90.00
91.00 09100	EMERGENCY	1,573,990	14,775	111	72,218	1,661,094 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,790,557	365,917	312,379	785,988	12,745,095 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	70,183	37,996	0	7,466	115,645 192.00
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	12,860,740	403,913	312,379	793,454	12,860,740 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	2,115,248					5.00
6.00	00600	70,576	429,105				6.00
7.00	00700	76,873	61,300	528,689			7.00
8.00	00800	15,830	5,389	7,746	109,381		8.00
9.00	00900	59,842	1,730	2,487	0	368,055	9.00
10.00	01000	55,076	35,639	51,228	0	0	10.00
11.00	01100	15,144	0	0	0	12,029	11.00
13.00	01300	88,738	2,439	3,506	0	0	13.00
16.00	01600	48,228	7,556	10,862	0	8,719	16.00
17.00	01700	281	1,772	2,547	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	223,229	43,154	62,031	33,545	71,405	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	74,390	46,277	66,520	19,227	39,840	50.00
53.00	05301	2,702	742	1,066	0	0	53.00
54.00	05400	177,729	19,843	28,522	19,575	16,444	54.00
60.00	06000	189,417	10,943	15,730	5,730	18,982	60.00
65.00	06500	65,789	9,757	14,024	707	12,360	65.00
66.00	06600	38,721	9,427	13,550	2,323	16,665	66.00
71.00	07100	30,844	18,195	26,153	0	7,063	71.00
73.00	07300	101,720	7,663	11,016	0	8,056	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	276,913	50,595	72,727	1,444	57,167	88.00
88.01	08801	69,406	10,902	15,671	0	9,712	88.01
90.00	09000	84,051	20,296	29,174	0	8,719	90.00
91.00	09100	326,984	18,335	26,354	26,400	47,455	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,092,483	381,954	460,914	108,951	334,616	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	22,765	47,151	67,775	430	33,439	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,115,248	429,105	528,689	109,381	368,055	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	421,729					10.00
11.00	01100	0	104,107				11.00
13.00	01300	0	6,910	552,383			13.00
16.00	01600	0	4,943	0	325,308		16.00
17.00	01700	0	0	0	0	6,028	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	421,729	15,987	264,781	14,996	6,028	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	6,500	73,512	10,950	0	50.00
53.00	05301	0	0	0	709	0	53.00
54.00	05400	0	10,129	0	87,793	0	54.00
60.00	06000	0	10,739	0	79,971	0	60.00
65.00	06500	0	5,122	0	22,940	0	65.00
66.00	06600	0	968	0	8,307	0	66.00
71.00	07100	0	2,125	0	5,197	0	71.00
73.00	07300	0	2,303	0	23,450	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	19,501	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
90.00	09000	0	4,954	0	15,947	0	90.00
91.00	09100	0	12,916	214,090	55,048	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		421,729	103,097	552,383	325,308	6,028	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	1,010	0	0	0	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		421,729	104,107	552,383	325,308	6,028	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,290,891	0	2,290,891	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	715,118	0	715,118	50.00
53.00	05301	18,947	0	18,947	53.00
54.00	05400	1,262,898	0	1,262,898	54.00
60.00	06000	1,293,751	0	1,293,751	60.00
65.00	06500	464,909	0	464,909	65.00
66.00	06600	286,662	0	286,662	66.00
71.00	07100	246,267	0	246,267	71.00
73.00	07300	670,948	0	670,948	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	1,885,066	0	1,885,066	88.00
88.01	08801	458,272	0	458,272	88.01
90.00	09000	590,120	0	590,120	90.00
91.00	09100	2,388,676	0	2,388,676	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		12,572,525	0	12,572,525	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	288,215	0	288,215	192.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		12,860,740	0	12,860,740	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	1,474	0	1,474	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,486	40,845	14,083	57,414	5.00
6.00 00600	MAINTENANCE & REPAIRS	77	15,804	7,772	23,653	6.00
7.00 00700	OPERATION OF PLANT	0	49,396	3,178	52,574	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,343	0	4,343	8.00
9.00 00900	HOUSEKEEPING	0	1,394	0	1,394	9.00
10.00 01000	DIETARY	0	28,720	1,865	30,585	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,966	0	1,966	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	527	6,089	9,795	16,411	16.00
17.00 01700	SOCIAL SERVICE	0	1,428	0	1,428	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,178	34,776	125,705	167,659	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,346	37,292	45,304	83,942	50.00
53.00 05301	ANESTHESIOLOGY	3,750	598	88	4,436	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	80,880	15,990	65,890	162,760	54.00
60.00 06000	LABORATORY	32,962	8,818	9,655	51,435	60.00
65.00 06500	RESPIRATORY THERAPY	8,079	7,862	2,363	18,304	65.00
66.00 06600	PHYSICAL THERAPY	240	7,597	325	8,162	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,662	700	15,362	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	6,176	7,360	13,536	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	793	40,772	0	41,565	88.00
88.01 08801	RURAL HEALTH CLINIC (RHC)	0	8,785	9,942	18,727	88.01
90.00 09000	CLINIC	0	16,355	8,243	24,598	90.00
91.00 09100	EMERGENCY	4,697	14,775	111	19,583	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	143,015	365,917	312,379	821,311	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	720	37,996	0	38,716	192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	143,735	403,913	312,379	860,027	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	57,617					5.00
6.00	00600	1,922	25,610				6.00
7.00	00700	2,094	3,658	58,326			7.00
8.00	00800	431	322	855	5,951		8.00
9.00	00900	1,630	103	274	0	3,453	9.00
10.00	01000	1,500	2,127	5,652	0	0	10.00
11.00	01100	413	0	0	0	113	11.00
13.00	01300	2,417	146	387	0	0	13.00
16.00	01600	1,314	451	1,198	0	82	16.00
17.00	01700	8	106	281	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,081	2,576	6,843	1,826	670	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,026	2,762	7,339	1,046	374	50.00
53.00	05301	74	44	118	0	0	53.00
54.00	05400	4,841	1,184	3,147	1,065	154	54.00
60.00	06000	5,160	653	1,735	312	178	60.00
65.00	06500	1,792	582	1,547	38	116	65.00
66.00	06600	1,055	563	1,495	126	156	66.00
71.00	07100	840	1,086	2,885	0	66	71.00
73.00	07300	2,771	457	1,215	0	76	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	7,543	3,020	8,024	79	536	88.00
88.01	08801	1,891	651	1,729	0	91	88.01
90.00	09000	2,289	1,211	3,218	0	82	90.00
91.00	09100	8,905	1,094	2,907	1,436	445	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		56,997	22,796	50,849	5,928	3,139	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	620	2,814	7,477	23	314	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		57,617	25,610	58,326	5,951	3,453	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/28/2012 4:07 pm
-------------------------------------	--	----------------------	---	---

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	39,911					10.00
11.00	01100	0	540				11.00
13.00	01300	0	36	5,036			13.00
16.00	01600	0	26	0	19,519		16.00
17.00	01700	0	0	0	0	1,823	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	39,911	83	2,414	900	1,823	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	34	670	657	0	50.00
53.00	05301	0	0	0	43	0	53.00
54.00	05400	0	53	0	5,268	0	54.00
60.00	06000	0	56	0	4,798	0	60.00
65.00	06500	0	27	0	1,376	0	65.00
66.00	06600	0	5	0	498	0	66.00
71.00	07100	0	11	0	312	0	71.00
73.00	07300	0	12	0	1,407	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	99	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
90.00	09000	0	26	0	957	0	90.00
91.00	09100	0	67	1,952	3,303	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		39,911	535	5,036	19,519	1,823	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	5	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		39,911	540	5,036	19,519	1,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	230,919	0	230,919	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	98,901	0	98,901	50.00
53.00	05301	4,715	0	4,715	53.00
54.00	05400	178,581	0	178,581	54.00
60.00	06000	64,413	0	64,413	60.00
65.00	06500	23,834	0	23,834	65.00
66.00	06600	12,065	0	12,065	66.00
71.00	07100	20,577	0	20,577	71.00
73.00	07300	19,508	0	19,508	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	61,123	0	61,123	88.00
88.01	08801	23,150	0	23,150	88.01
90.00	09000	32,432	0	32,432	90.00
91.00	09100	39,826	0	39,826	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		810,044	0	810,044	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	49,983	0	49,983	192.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		860,027	0	860,027	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	60,827				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		252,890			2.00
4.00 00400	EMPLOYEE BENEFITS	222	0	6,323,471		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,151	11,401	869,355	-2,115,248	10,745,492 5.00
6.00 00600	MAINTENANCE & REPAIRS	2,380	6,292	151,393	0	358,529 6.00
7.00 00700	OPERATION OF PLANT	7,439	2,573	0	0	390,516 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	654	0	0	0	80,416 8.00
9.00 00900	HOUSEKEEPING	210	0	221,530	0	303,996 9.00
10.00 01000	DIETARY	4,325	1,510	201,210	0	279,786 10.00
11.00 01100	CAFETERIA	0	0	61,466	0	76,934 11.00
13.00 01300	NURSING ADMINISTRATION	296	0	360,832	0	450,790 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	917	7,930	158,975	0	245,000 16.00
17.00 01700	SOCIAL SERVICE	215	0	0	0	1,428 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,237	101,766	570,465	0	1,134,006 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,616	36,676	217,767	0	377,902 50.00
53.00 05301	ANESTHESIOLOGY	90	71	0	0	13,728 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,408	53,342	467,634	0	902,863 54.00
60.00 06000	LABORATORY	1,328	7,816	368,666	0	962,239 60.00
65.00 06500	RESPIRATORY THERAPY	1,184	1,913	224,555	0	334,210 65.00
66.00 06600	PHYSICAL THERAPY	1,144	263	19,699	0	196,701 66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,208	567	65,562	0	156,690 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	930	5,958	145,808	0	516,740 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	6,140	0	1,104,393	0	1,406,719 88.00
88.01 08801	RURAL HEALTH CLINIC (RHC)	1,323	8,049	261,258	0	352,581 88.01
90.00 09000	CLINIC	2,463	6,673	217,857	0	426,979 90.00
91.00 09100	EMERGENCY	2,225	90	575,545	0	1,661,094 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,105	252,890	6,263,970	-2,115,248	10,629,847 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,722	0	59,501	0	115,645 192.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	403,913	312,379	793,454		2,115,248 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.640357	1.235237	0.125478		0.196850 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			1,474		57,617 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000233		0.005362 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	52,074				6.00
7.00	00700	OPERATION OF PLANT	7,439	44,635			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	654	84,376		8.00
9.00	00900	HOUSEKEEPING	210	210	0	3,335	9.00
10.00	01000	DIETARY	4,325	4,325	0	0	6,319
11.00	01100	CAFETERIA	0	0	0	109	0
13.00	01300	NURSING ADMINISTRATION	296	296	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	917	917	0	79	0
17.00	01700	SOCIAL SERVICE	215	215	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,237	5,237	25,876	647	6,319
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,616	5,616	14,832	361	0
53.00	05301	ANESTHESIOLOGY	90	90	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,408	2,408	15,100	149	0
60.00	06000	LABORATORY	1,328	1,328	4,420	172	0
65.00	06500	RESPIRATORY THERAPY	1,184	1,184	545	112	0
66.00	06600	PHYSICAL THERAPY	1,144	1,144	1,792	151	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,208	2,208	0	64	0
73.00	07300	DRUGS CHARGED TO PATIENTS	930	930	0	73	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,140	6,140	1,114	518	0
88.01	08801	RURAL HEALTH CLINIC (RHC)	1,323	1,323	0	88	0
90.00	09000	CLINIC	2,463	2,463	0	79	0
91.00	09100	EMERGENCY	2,225	2,225	20,365	430	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,352	38,913	84,044	3,032	6,319
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,722	5,722	332	303	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	429,105	528,689	109,381	368,055	421,729
203.00		Unit cost multiplier (Wkst. B, Part I)	8.240293	11.844718	1.296352	110.361319	66.739832
204.00		Cost to be allocated (per Wkst. B, Part II)	25,610	58,326	5,951	3,453	39,911
205.00		Unit cost multiplier (Wkst. B, Part II)	0.491800	1.306732	0.070530	1.035382	6.316031

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		CAFETERIA (FTE)	NURSING ADMINISTRATION (DIRECT NURS. HRS. FTE)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	9,898				11.00
13.00	01300	657	3,171			13.00
16.00	01600	470	0	26,058,190		16.00
17.00	01700	0	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	1,520	1,520	1,201,215	100	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	618	422	877,098	0	50.00
53.00	05301	0	0	56,758	0	53.00
54.00	05400	963	0	7,032,674	0	54.00
60.00	06000	1,021	0	6,405,900	0	60.00
65.00	06500	487	0	1,837,536	0	65.00
66.00	06600	92	0	665,395	0	66.00
71.00	07100	202	0	416,325	0	71.00
73.00	07300	219	0	1,878,419	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	1,854	0	0	0	88.00
88.01	08801	0	0	0	0	88.01
90.00	09000	471	0	1,277,370	0	90.00
91.00	09100	1,228	1,229	4,409,500	0	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		9,802	3,171	26,058,190	100	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	96	0	0	0	192.00
200.00						200.00
201.00						201.00
202.00		104,107	552,383	325,308	6,028	202.00
203.00		10.517983	174.198360	0.012484	60.280000	203.00
204.00		540	5,036	19,519	1,823	204.00
205.00		0.054556	1.588143	0.000749	18.230000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,290,891		2,290,891	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	715,118		715,118	0	0	50.00
53.00	05301 ANESTHESIOLOGY	18,947		18,947	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,262,898		1,262,898	0	0	54.00
60.00	06000 LABORATORY	1,293,751		1,293,751	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	464,909	0	464,909	0	0	65.00
66.00	06600 PHYSICAL THERAPY	286,662	0	286,662	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	246,267		246,267	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	670,948		670,948	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	1,885,066		1,885,066	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)	458,272		458,272	0	0	88.01
90.00	09000 CLINIC	590,120		590,120	0	0	90.00
91.00	09100 EMERGENCY	2,388,676		2,388,676	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	306,484		306,484	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	12,879,009	0	12,879,009	0	0	200.00
201.00	Less Observation Beds	306,484		306,484			201.00
202.00	Total (see instructions)	12,572,525	0	12,572,525	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			Cost		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	997,030		997,030		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,982	859,116	877,098	0.815323	50.00
53.00	05301	ANESTHESIOLOGY	1,534	55,224	56,758	0.333821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,221	6,822,453	7,032,674	0.179576	54.00
60.00	06000	LABORATORY	340,867	6,065,033	6,405,900	0.201962	60.00
65.00	06500	RESPIRATORY THERAPY	349,278	1,488,258	1,837,536	0.253007	65.00
66.00	06600	PHYSICAL THERAPY	75,885	589,510	665,395	0.430815	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	214,827	201,498	416,325	0.591526	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	502,604	1,375,815	1,878,419	0.357188	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,252,358	1,252,358		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	201,751	201,751		88.01
90.00	09000	CLINIC	0	1,277,370	1,277,370	0.461980	90.00
91.00	09100	EMERGENCY	33,908	4,375,592	4,409,500	0.541711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	204,185	204,185	1.501011	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,744,136	24,768,163	27,512,299		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,744,136	24,768,163	27,512,299		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05301 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)				88.01
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 141321		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part II Date/Time Prepared: 11/28/2012 4:07 pm	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital Cost								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	98,901	877,098	0.112759	5,174	583	50.00
53.00	05301	ANESTHESIOLOGY	4,715	56,758	0.083072	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,581	7,032,674	0.025393	130,303	3,309	54.00
60.00	06000	LABORATORY	64,413	6,405,900	0.010055	238,664	2,400	60.00
65.00	06500	RESPIRATORY THERAPY	23,834	1,837,536	0.012971	261,559	3,393	65.00
66.00	06600	PHYSICAL THERAPY	12,065	665,395	0.018132	45,338	822	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,577	416,325	0.049425	156,983	7,759	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,508	1,878,419	0.010385	352,649	3,662	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	61,123	1,252,358	0.048806	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	23,150	201,751	0.114745	0	0	88.01
90.00	09000	CLINIC	32,432	1,277,370	0.025390	0	0	90.00
91.00	09100	EMERGENCY	39,826	4,409,500	0.009032	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	204,185	0.000000	0	0	92.00
200.00		Total (lines 50-199)	579,125	26,515,269		1,190,670	21,928	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/28/2012 4:07 pm
--	----------------------	---	---

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05301	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/28/2012 4:07 pm
--	----------------------	---	---

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	877,098	0.000000	0.000000	5,174	50.00
53.00	05301 ANESTHESIOLOGY	0	56,758	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,032,674	0.000000	0.000000	130,303	54.00
60.00	06000 LABORATORY	0	6,405,900	0.000000	0.000000	238,664	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,837,536	0.000000	0.000000	261,559	65.00
66.00	06600 PHYSICAL THERAPY	0	665,395	0.000000	0.000000	45,338	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	416,325	0.000000	0.000000	156,983	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,878,419	0.000000	0.000000	352,649	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	1,252,358	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)	0	201,751	0.000000	0.000000	0	88.01
90.00	09000 CLINIC	0	1,277,370	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	4,409,500	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	204,185	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	26,515,269			1,190,670	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/28/2012 4:07 pm
		Title XVIII	Hospital
		Cost	

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05301 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)	0	0	0	88.01
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/28/2012 4:07 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.815323	0	366,091	0		50.00
53.00 05301 ANESTHESIOLOGY	0.333821	0	22,656	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.179576	0	2,127,460	0		54.00
60.00 06000 LABORATORY	0.201962	0	2,223,218	0		60.00
65.00 06500 RESPIRATORY THERAPY	0.253007	0	724,513	0		65.00
66.00 06600 PHYSICAL THERAPY	0.430815	0	188,995	0		66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.591526	0	96,299	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.357188	0	528,222	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00
88.01 08801 RURAL HEALTH CLINIC (RHC)	0.000000					88.01
90.00 09000 CLINIC	0.461980	0	1,104,997	0		90.00
91.00 09100 EMERGENCY	0.541711	0	1,188,598	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.501011	0	122,475	0		92.00
200.00 Subtotal (see instructions)		0	8,693,524	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	8,693,524	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/28/2012 4:07 pm
Title XVIII		Hospital	Cost

Cost Center Description	Costs					
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	298,482	0	50.00
53.00	05301	ANESTHESIOLOGY	0	7,563	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	382,041	0	54.00
60.00	06000	LABORATORY	0	449,006	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	183,307	0	65.00
66.00	06600	PHYSICAL THERAPY	0	81,422	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	56,963	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	188,675	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	88.01
90.00	09000	CLINIC	0	510,487	0	90.00
91.00	09100	EMERGENCY	0	643,877	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	183,836	0	92.00
200.00		Subtotal (see instructions)	0	2,985,659	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	2,985,659	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141321 Component CCN: 14Z321	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/28/2012 4:07 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.815323	0	0	0	50.00
53.00	05301	ANESTHESIOLOGY	0.333821	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179576	0	0	0	54.00
60.00	06000	LABORATORY	0.201962	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.253007	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.430815	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.591526	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.357188	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000				88.01
90.00	09000	CLINIC	0.461980	0	0	0	90.00
91.00	09100	EMERGENCY	0.541711	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.501011	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141321 Component CCN: 14Z321	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/28/2012 4:07 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05301 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)	0	0	0	88.01
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Subtotal (see instructions)	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/28/2012 4:07 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,480	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,360	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,162	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		60	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		60	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		824	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		60	10.00
11.00	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)		60	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,290,891	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		185,748	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,105,143	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,201,215	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,201,215	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.752511	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,033.75	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,105,143	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,547.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,275,470	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,275,470	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141321		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/28/2012 4:07 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					380,348	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,655,818	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0 54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)						0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0 57.00
58.00	Bonus payment (see instructions)						0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0 61.00
62.00	Relief payment (see instructions)						0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					92,874	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					92,874	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					185,748	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					198	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,547.90	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					306,484	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141321		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/28/2012 4:07 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/28/2012 4:07 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		762,950		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.815323	5,174	4,218	50.00
53.00	05301 ANESTHESIOLOGY	0.333821	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.179576	130,303	23,399	54.00
60.00	06000 LABORATORY	0.201962	238,664	48,201	60.00
65.00	06500 RESPIRATORY THERAPY	0.253007	261,559	66,176	65.00
66.00	06600 PHYSICAL THERAPY	0.430815	45,338	19,532	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.591526	156,983	92,860	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.357188	352,649	125,962	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)	0.000000		0	88.01
90.00	09000 CLINIC	0.461980	0	0	90.00
91.00	09100 EMERGENCY	0.541711	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.501011	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,190,670	380,348	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0	201.00
202.00	Net Charges (line 200 minus line 201)		1,190,670		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3	
		Component CCN: 14Z321		Date/Time Prepared: 11/28/2012 4:07 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.815323	0	0	50.00
53.00	05301 ANESTHESIOLOGY	0.333821	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.179576	5,025	902	54.00
60.00	06000 LABORATORY	0.201962	10,874	2,196	60.00
65.00	06500 RESPIRATORY THERAPY	0.253007	19,056	4,821	65.00
66.00	06600 PHYSICAL THERAPY	0.430815	23,125	9,963	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.591526	23,264	13,761	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.357188	36,683	13,103	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC (RHC)	0.000000		0	88.01
90.00	09000 CLINIC	0.461980	0	0	90.00
91.00	09100 EMERGENCY	0.541711	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.501011	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		118,027	44,746	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		118,027		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/28/2012 4:07 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,985,659 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,985,659 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	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)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,015,516 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			29,338 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,288,735 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,697,443 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,697,443 30.00
31.00	Primary payer payments			34 31.00
32.00	Subtotal (line 30 minus line 31)			1,697,409 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			464,432 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			464,432 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			464,432 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,161,841 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			2,161,841 40.00
41.00	Interim payments			2,319,453 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			-157,612 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,823,833		2,817,196	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	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)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	03/30/2012	188,858	03/30/2012	433,572	3.50	
3.51		06/29/2012	56,140	06/29/2012	64,171	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-244,998		-497,743	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,578,835		2,319,453	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		24,702		157,612	6.02	
7.00	Total Medicare program liability (see instructions)		1,554,133		2,161,841	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141321
Component CCN: 14Z321

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2012 4:07 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		268,412		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	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)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	03/30/2012	29,672		0	3.50
3.51		06/29/2012	2,089		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-31,761		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		236,651		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		3,853		0	6.02
7.00	Total Medicare program liability (see instructions)		232,798		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part II
Date/Time Prepared:
11/28/2012 4:07 pm

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			326 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			824 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			0 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,162 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			27,512,299 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			396,248 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141321	Period: From 07/01/2011	Worksheet E-2
Component CCN: 14Z321	To 06/30/2012	Date/Time Prepared: 11/28/2012 4:07 pm
Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	187,605	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	45,193	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	120	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	232,798	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	232,798	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	232,798	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	232,798	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	232,798	0	19.00
20.00	Interim payments	236,651	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-3,853	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 11/28/2012 4:07 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		1,655,818	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		1,655,818	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,672,376	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	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)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,672,376	19.00
20.00	Deductibles (exclude professional component)		160,383	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		1,511,993	22.00
23.00	Coinsurance		578	23.00
24.00	Subtotal (line 22 minus line 23)		1,511,415	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		42,718	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		42,718	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		42,718	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,554,133	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		1,554,133	30.00
31.00	Interim payments		1,578,835	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		-24,702	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet G

Date/Time Prepared:
11/28/2012 4:07 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,463,270	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,230,847	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	233,651	0	0	0	7.00
8.00	Prepaid expenses	55,871	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,983,639	0	0	0	11.00
FIXED ASSETS						
12.00	Land	18,401	0	0	0	12.00
13.00	Land improvements	103,779	0	0	0	13.00
14.00	Accumulated depreciation	-92,792	0	0	0	14.00
15.00	Buildings	4,557,832	0	0	0	15.00
16.00	Accumulated depreciation	-4,411,619	0	0	0	16.00
17.00	Leasehold improvements	4,607,742	0	0	0	17.00
18.00	Accumulated depreciation	-3,812,361	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,407,978	0	0	0	23.00
24.00	Accumulated depreciation	-5,432,339	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	411,343	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,357,964	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	881,265	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	881,265	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,222,868	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,968,514	0	0	0	37.00
38.00	Salaries, wages, and fees payable	661,818	0	0	0	38.00
39.00	Payroll taxes payable	94,022	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	118,375	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,842,729	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	725,943	0	0	0	47.00
48.00	Unsecured loans	1,079,566	0	0	0	48.00
49.00	Other long term liabilities	4,209,571	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,015,080	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,857,809	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-634,941	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-634,941	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,222,868	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-1

Date/Time Prepared:
11/28/2012 4:07 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		-1,082,994	
2.00	Net income (loss) (From Wkst. G-3, line 29)		448,053			2.00
3.00	Total (sum of line 1 and line 2)		-634,941		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		-634,941		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-634,941		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-1

Date/Time Prepared:
11/28/2012 4:07 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00			0		0	10.00
11.00			0		0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2012 4:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	958,485		958,485	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	958,485		958,485	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	958,485		958,485	17.00
18.00	Ancillary services	1,755,803	17,399,073	19,154,876	18.00
19.00	Outpatient services	38,319	4,583,996	4,622,315	19.00
20.00	RURAL HEALTH CLINIC	0	2,662,604	2,662,604	20.00
20.01	RURAL HEALTH CLINIC (RHC)	0	219,882	219,882	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	10,794	2,175,585	2,186,379	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,763,401	27,041,140	29,804,541	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,452,230		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,452,230		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141321

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-3

Date/Time Prepared:
11/28/2012 4:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	29,804,541	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,245,109	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,559,432	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,452,230	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-892,798	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	12,337	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5,741	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	220,591	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	95,967	16.00
17.00	Revenue from sale of drugs to other than patients	2,043	17.00
18.00	Revenue from sale of medical records and abstracts	360,531	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	8,300	22.00
23.00	Governmental appropriations	-139,535	23.00
24.00	PROPERTY AND REPL TAX INC AND OTHER	774,876	24.00
25.00	Total other income (sum of lines 6-24)	1,340,851	25.00
26.00	Total (line 5 plus line 25)	448,053	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	448,053	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1 Date/Time Prepared: 11/28/2012 4:07 pm
--	---	---	--

		Title XVIII		Rural Health Clinic (RHC) I	Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	567,442	0	567,442	62,093	629,535	1.00
2.00	Physician Assistant	93,817	0	93,817	0	93,817	2.00
3.00	Nurse Practitioner	210,043	0	210,043	4,206	214,249	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	281,322	0	281,322	0	281,322	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	1,152,624	0	1,152,624	66,299	1,218,923	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	12,900	12,900	0	12,900	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	11,032	11,032	0	11,032	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	23,932	23,932	0	23,932	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,152,624	23,932	1,176,556	66,299	1,242,855	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	12,280	12,280	0	12,280	29.00
30.00	Administrative Costs	102,750	95,386	198,136	3,106	201,242	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	102,750	107,666	210,416	3,106	213,522	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,255,374	131,598	1,386,972	69,405	1,456,377	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1 Date/Time Prepared: 11/28/2012 4:07 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
	6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-217,280	412,255	1.00
2.00	Physician Assistant	0	93,817	2.00
3.00	Nurse Practitioner	0	214,249	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	281,322	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	-217,280	1,001,643	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	12,900	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	11,032	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	23,932	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-217,280	1,025,575	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	12,280	29.00
30.00	Administrative Costs	-11,725	189,517	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-11,725	201,797	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-229,005	1,227,372	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141321 Component CCN: 148510	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1 Date/Time Prepared: 11/28/2012 4:07 pm
--	---	---	--

		Title XVIII		Rural Health Clinic (RHC) II	Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	176,487	0	176,487	-62,093	114,394	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	89,301	0	89,301	-4,206	85,095	3.00
4.00	Visiting Nurse	34,889	0	34,889	0	34,889	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	300,677	0	300,677	-66,299	234,378	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	4,773	4,773	0	4,773	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	4,773	4,773	0	4,773	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	300,677	4,773	305,450	-66,299	239,151	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	5,066	5,066	0	5,066	29.00
30.00	Administrative Costs	30,552	38,741	69,293	-8,726	60,567	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	30,552	43,807	74,359	-8,726	65,633	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	331,229	48,580	379,809	-75,025	304,784	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141321 Component CCN: 148510	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1 Date/Time Prepared: 11/28/2012 4:07 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
	6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-3,671	110,723	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	85,095	3.00
4.00	Visiting Nurse	0	34,889	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	-3,671	230,707	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	4,773	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	4,773	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-3,671	235,480	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	5,066	29.00
30.00	Administrative Costs	-41	60,526	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-41	65,592	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,712	301,072	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141321	Period: From 07/01/2011	Worksheet M-2		
		Component CCN: 143469	To 06/30/2012	Date/Time Prepared: 11/28/2012 4:07 pm		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.53	3,625	4,200	6,426	1.00
2.00	Physician Assistant	0.96	2,601	2,100	2,016	2.00
3.00	Nurse Practitioner	2.35	5,338	2,100	4,935	3.00
4.00	Subtotal (sum of lines 1-3)	4.84	11,564		13,377	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	4.84	11,564		13,377	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				1,025,575	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,025,575	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				201,797	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				657,694	15.00
16.00	Total overhead (sum of lines 14 and 15)				859,491	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				859,491	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				859,491	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,885,066	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141321 Component CCN: 148510	Period: From 07/01/2011 To 06/30/2012	Worksheet M-2 Date/Time Prepared: 11/28/2012 4:07 pm		
		Title XVIII	Rural Health Clinic (RHC) II	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3) 4.00	Greater of col. 2 or col. 4 5.00	
VI SITS AND PRODUCTI VI TY						
Posi tions						
1.00	Physi ci an	0.34	534	4,200	1,428	1.00
2.00	Physi ci an Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.47	1,385	2,100	987	3.00
4.00	Subtotal (sum of lines 1-3)	0.81	1,919		2,415	4.00
5.00	Visi ting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medi cal Nutri tion Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Sel f Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.81	1,919		2,415	8.00
9.00	Physi ci an Servi ces Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLI CABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				235,480	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				235,480	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				65,592	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				157,200	15.00
16.00	Total overhead (sum of lines 14 and 15)				222,792	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				222,792	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				222,792	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				458,272	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3 Date/Time Prepared: 11/28/2012 4:07 pm
		Title XVIIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,885,066	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		1,136	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,883,930	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		13,377	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		13,377	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		140.83	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	140.83	140.83	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,286	1,287	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	181,107	181,248	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	181,107	181,248	16.00
16.01	Total program charges (see instructions)(from contractor's records)		263,444	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		258,639	16.04
16.05	Total program cost (see instructions)		258,639	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,056	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		44,878	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		258,639	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		448	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		259,087	22.00
23.00	Reimbursable bad debts (see instructions)		15,490	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		15,490	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		274,577	26.00
27.00	Interim payments		324,051	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		-49,474	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141321	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3
		Component CCN: 148510		Date/Time Prepared: 11/28/2012 4:07 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		458,272	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		424	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		457,848	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,415	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,415	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		189.59	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	189.59	189.59	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	102	103	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	19,338	19,528	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	19,338	19,528	16.00
16.01	Total program charges (see instructions)(from contractor's records)		20,330	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		30,322	16.04
16.05	Total program cost (see instructions)		30,322	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		964	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,873	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		30,322	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		424	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		30,746	22.00
23.00	Reimbursable bad debts (see instructions)		3,315	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		3,315	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		34,061	26.00
27.00	Interim payments		31,087	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		2,974	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141321
Component CCN: 143469

Period:
From 07/01/2011
To 06/30/2012

Worksheet M-4
Date/Time Prepared:
11/28/2012 4:07 pm

Title XVIII

Rural Health
Clinic (RHC) I

Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	1,001,643	1,001,643	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000150	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	150	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	468	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	618	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,025,575	1,025,575	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	859,491	859,491	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000603	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	518	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	1,136	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	38	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	29.89	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	15	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	448	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		1,136	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		448	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141321
Component CCN: 148510

Period:
From 07/01/2011
To 06/30/2012

Worksheet M-4
Date/Time Prepared:
11/28/2012 4:07 pm

Title XVIII

Rural Health
Clinic (RHC) II

Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	230,707	230,707	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000303	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	70	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	148	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	218	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	235,480	235,480	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	222,792	222,792	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000926	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	206	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	424	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	12	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	35.33	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	12	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	424	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		424	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		424	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5 Date/Time Prepared: 11/28/2012 4:07 pm	
		Title VIII	Rural Health Clinic (RHC) I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider			296,673	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	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)				3.00
Program to Provider					
3.01			03/30/2012	27,378	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			27,378	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			324,051	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			49,474	6.02
7.00	Total Medicare program liability (see instructions)			274,577	7.00
			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 141321 Component CCN: 148510	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5 Date/Time Prepared: 11/28/2012 4:07 pm	
		Title XVIII	Rural Health Clinic (RHC) II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider			25,353	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	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)				3.00
Program to Provider					
3.01			03/30/2012	5,734	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			5,734	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			31,087	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			2,974	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			34,061	7.00
			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00