

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 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/21/2013 7:12 am
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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: 11/21/2013	Time: 7:12 am
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 certification 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 (141321) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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	-74,011	260,642	36,283	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	-827	0	0	0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		62,745		0	10.00
10.01 RURAL HEALTH CLINIC II	0		-3,368		0	10.01
200.00 Total	0	-74,838	320,019	36,283	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 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/21/2013 7:10 am
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
Street: 201 BAILEY LANE		PO Box:	Zip Code: 62812	County: FRANKLIN
City: BENTON		State: IL		

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
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	O	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	O	N	7.00
8.00	Swing Beds - NF									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	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	WEST FRANKFORT RHC	148510	14999		04/23/2010	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									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)	07/01/2012	06/30/2013	20.00
21.00	Type of Control (see instructions)	9		21.00

Inpatient PPS Information										
22.00	Does this facility qualify 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	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "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 unpaid	Medicaid HMO days	Other Medicaid days	
24.00	0	0	0	0	0	0	24.00
25.00	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	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "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

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		Beginning: 1.00	Ending: 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
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
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 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 additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? 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 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, 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	64.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	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

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	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
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					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 5th or 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 5th or 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	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					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.						86.00
				V	XIX		
				1.00	2.00		
Title V and XIX 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

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		V	XIX			
		1.00	2.00			
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	
		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	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00	
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	List amounts of malpractice premiums and paid losses:	196,074	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N	
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	

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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:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00

		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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	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	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	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	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.	Y	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)	450,715	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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/21/2013 7:10 am	
			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	12/31/2013	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		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
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	10/23/2013	Y	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		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		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		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		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/21/2013 7:10 am
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		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	
		Date	
		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)	10/23/2013	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)		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.		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.		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:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		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.	DIRECTOR	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 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2013 7:10 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / T r i p s	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	20,184.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	20,184.00	0	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	9,125	20,184.00	0	14.00
15.00 CAH visits					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
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	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					0	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 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2013 7:10 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	675	57	841			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	172	0	172			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	9			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	847	57	1,022			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)	847	57	1,022	0.00	133.74	14.00
15.00 CAH visits	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
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	2,567	3,913	11,419	0.00	18.96	26.00
26.01 RURAL HEALTH CLINIC II	123	435	1,216	0.00	3.06	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	155.76	27.00
28.00 Observation Bed Days		0	181			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 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2013 7:10 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	221	26	296	1.00
2.00 HMO and other (see instructions)				0			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							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	0	221	26		296	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
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.01 RURAL HEALTH CLINIC II	0.00						26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	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-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2012 To 06/30/2013	Worksheet S-8 Date/Time Prepared: 11/21/2013 7:10 am	
			Rural Health Clinic (RHC) I	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	
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 Tuesday					
		from to	from to	from	
		1.00 2.00	3.00 4.00	5.00	
11.00	Facility hours of operations (1)	Clinic		09:00 21:00 09:00 11.00	
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. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. 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 XVIII XIX 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. Enter in column 5 the number of total visits for this provider. (see instructions)	N 0		0 0 0 15.00	
County					
4.00					
2.00	City, State, Zip Code, County			2.00	
Tuesday Wednesday Thursday					
		to from to	from to		
		6.00 7.00 8.00	9.00 10.00		
11.00	Facility hours of operations (1)	Clinic		21:00 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 07/01/2012 To 06/30/2013	Worksheet S-8 Date/Time Prepared: 11/21/2013 7:10 am		
			Rural Health Clinic (RHC) I	Cost		
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
11.00	Facility hours of operations (1) Clinic	09:00	21:00	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 07/01/2012 To 06/30/2013		Worksheet S-8 Date/Time Prepared: 11/21/2013 7:10 am	
				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	
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							
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		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00 Facility hours of operations (1)							
11.00 Clinic				09:00 17:00		09:00 11.00	
1.00							
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. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. 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		XVIII	
		1.00		2.00		3.00	
		N		0		0	
						XIX	
						0	
						Total Visits	
						0	
						0 15.00	
County							
4.00							
2.00 City, State, Zip Code, County						2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00 Facility hours of operations (1)							
11.00 Clinic		17:00 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 07/01/2012 To 06/30/2013	Worksheet S-8 Date/Time Prepared: 11/21/2013 7:10 am	
			Rural Health Clinic (RHC) II	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	09:00	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/21/2013 7:10 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.454513	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,928,876	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		6,789,428	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,085,883	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)		1,157,007	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)		1,157,007	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	453,160	14,349	467,509	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	205,967	6,522	212,489	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)	205,967	6,522	212,489	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)		2,955,577	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		525,792	27.00	
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		2,429,785	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,104,369	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,316,858	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,473,865	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet A
Date/Time Prepared:
11/21/2013 7:10 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		181,680	181,680	215,783	397,463	1.00
2.00	00200		240,068	240,068	18,586	258,654	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	55,499	572,060	627,559	9,172	636,731	4.00
5.00	00500	970,215	1,058,419	2,028,634	120,875	2,149,509	5.00
6.00	00600	163,422	221,619	385,041	-216	384,825	6.00
7.00	00700	0	329,862	329,862	8,483	338,345	7.00
8.00	00800	0	69,756	69,756	0	69,756	8.00
9.00	00900	223,810	46,227	270,037	0	270,037	9.00
10.00	01000	213,315	130,544	343,859	-248,878	94,981	10.00
11.00	01100	0	0	0	248,878	248,878	11.00
13.00	01300	383,679	45,101	428,780	0	428,780	13.00
16.00	01600	146,738	52,831	199,569	0	199,569	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	550,516	214,206	764,722	0	764,722	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	576,932	75,879	652,811	0	652,811	50.00
53.00	05300	0	55,671	55,671	-374	55,297	53.00
54.00	05400	446,327	289,103	735,430	0	735,430	54.00
60.00	06000	391,226	633,776	1,025,002	0	1,025,002	60.00
65.00	06500	231,165	106,612	337,777	-2,452	335,325	65.00
66.00	06600	21,566	125,768	147,334	0	147,334	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	65,106	38,422	103,528	2,826	106,354	71.00
73.00	07300	164,517	307,506	472,023	0	472,023	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,259,199	172,690	1,431,889	17,055	1,448,944	88.00
88.01	08801	150,281	42,205	192,486	20,191	212,677	88.01
90.00	09000	441,405	222,387	663,792	-36,476	627,316	90.00
91.00	09100	589,906	1,509,009	2,098,915	-534	2,098,381	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		366,210	366,210	-366,210	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00		7,044,824	7,107,611	14,152,435	6,709	14,159,144	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	214,176	70,997	285,173	-6,709	278,464	192.00
200.00		7,259,000	7,178,608	14,437,608	0	14,437,608	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet A
Date/Time Prepared:
11/21/2013 7:10 am

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	-12,495	384,968	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-73,668	184,986	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,781	631,950	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-65,811	2,083,698	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	384,825	6.00
7.00	00700	OPERATION OF PLANT	-105,714	232,631	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	69,756	8.00
9.00	00900	HOUSEKEEPING	0	270,037	9.00
10.00	01000	DIETARY	0	94,981	10.00
11.00	01100	CAFETERIA	-49,132	199,746	11.00
13.00	01300	NURSING ADMINISTRATION	0	428,780	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,669	190,900	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	764,722	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-388,071	264,740	50.00
53.00	05300	ANESTHESIOLOGY	-44,341	10,956	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	735,430	54.00
60.00	06000	LABORATORY	-25,677	999,325	60.00
65.00	06500	RESPIRATORY THERAPY	-38,250	297,075	65.00
66.00	06600	PHYSICAL THERAPY	0	147,334	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	106,354	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,570	470,453	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-116,909	1,332,035	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	212,677	88.01
90.00	09000	CLINIC	-54,846	572,470	90.00
91.00	09100	EMERGENCY	-374,228	1,724,153	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
114.00	11400	UTILIZATION REVIEW - SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,364,162	12,794,982	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	278,464	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,364,162	13,073,446	200.00

RECLASSIFICATIONS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-6

Date/Time Prepared:
11/21/2013 7:10 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - TO RECLASS DIETARY COST						
1.00	CAFETERIA	11.00	154,393	94,485	1.00	
	TOTALS		154,393	94,485		
B - TO RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	183,692	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	182,518	2.00	
	TOTALS		0	366,210		
C - TO RECLASS PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00	0	50,677	1.00	
	TOTALS		0	50,677		
D - TO RECLASS HEALTH AND LIFE INSURANCE						
1.00	EMPLOYEE BENEFITS	4.00	0	9,172	1.00	
	TOTALS		0	9,172		
E - TO RECLASS RURAL HEALTH CLINIC COST						
1.00	RURAL HEALTH CLINIC	88.00	44,190	2,842	1.00	
2.00	RURAL HEALTH CLINIC II	88.01	28,266	1,711	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		72,456	4,553		
F - TO RECLASS TELEPHONE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	8,483	1.00	
2.00		0.00	0	0	2.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
	TOTALS		0	8,483		
G - TO RECLASS OXYGEN EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,826	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	2,826		
500.00	Grand Total: Increases		226,849	536,406	500.00	

RECLASSIFICATIONS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-6

Date/Time Prepared:
11/21/2013 7:10 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - TO RECLASS DIETARY COST							
1.00	DIETARY	10.00	154,393	94,485	0		1.00
	TOTALS		154,393	94,485			
B - TO RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	366,210	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	366,210			
C - TO RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,677	0		1.00
	TOTALS		0	50,677			
D - TO RECLASS HEALTH AND LIFE INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,172	0		1.00
	TOTALS		0	9,172			
E - TO RECLASS RURAL HEALTH CLINIC COST							
1.00	CLINIC	90.00	33,688	2,201	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	6,374	335	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	28,266	1,711	0		3.00
4.00	RURAL HEALTH CLINIC II	88.01	4,128	306	0		4.00
	TOTALS		72,456	4,553			
F - TO RECLASS TELEPHONE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,794	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	216	0		2.00
4.00	RURAL HEALTH CLINIC II	88.01	0	5,352	0		4.00
5.00	CLINIC	90.00	0	587	0		5.00
6.00	EMERGENCY	91.00	0	534	0		6.00
	TOTALS		0	8,483			
G - TO RECLASS OXYGEN EXPENSE							
1.00	ANESTHESIOLOGY	53.00	0	374	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	2,452	0		2.00
	TOTALS		0	2,826			
500.00	Grand Total: Decreases		226,849	536,406			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
11/21/2013 7:10 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	18,401	0	0	0	0	1.00
2.00	Land Improvements	103,779	0	0	0	0	2.00
3.00	Buildings and Fixtures	4,557,832	0	0	0	0	3.00
4.00	Building Improvements	4,607,742	0	0	0	0	4.00
5.00	Fixed Equipment	1,540,774	0	0	0	0	5.00
6.00	Movable Equipment	4,698,072	187,136	0	187,136	0	6.00
7.00	HIT designated Assets	169,132	324,926	0	324,926	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,695,732	512,062	0	512,062	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,695,732	512,062	0	512,062	0	10.00
		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	4,885,208	0				6.00
7.00	HIT designated Assets	494,058	0				7.00
8.00	Subtotal (sum of lines 1-7)	16,207,794	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	16,207,794	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
11/21/2013 7:10 am

Cost Center Description		SUMMARY OF CAPITAL					
		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	181,680	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	240,068	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	421,748	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		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	181,680				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	240,068				2.00
3.00	Total (sum of lines 1-2)	0	421,748				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part III
Date/Time Prepared:
11/21/2013 7:10 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	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	10,828,528	1,540,774	9,287,754	0.633241	32,091	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,379,266	0	5,379,266	0.366759	18,586	2.00
3.00	Total (sum of lines 1-2)	16,207,794	1,540,774	14,667,020	1.000000	50,677	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	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	32,091	181,680	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	18,586	166,400	0	2.00
3.00	Total (sum of lines 1-2)	0	0	50,677	348,080	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	171,197	32,091	0	0	384,968	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	18,586	0	0	184,986	2.00
3.00	Total (sum of lines 1-2)	171,197	50,677	0	0	569,954	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8

Date/Time Prepared:
11/21/2013 7:10 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-12,495	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00		2.00
3.00 Investment income - other (chapter 2)	B	-9,815	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	-1,892	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	-912,926				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	-49,132	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	-1,570	DRUGS CHARGED TO PATIENTS	73.00		17.00
18.00 Sale of medical records and abstracts	B	-8,669	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		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW - SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1.00		26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00		27.00
28.00 Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant				0.00		29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-60,745	CAP REL COSTS-MVBLE EQUIP	2.00		9 32.00
33.00 MISCELLANEOUS INC DEPRECIATION ADJ	A	-12,923	CAP REL COSTS-MVBLE EQUIP	2.00		9 33.00

Provider CCN: 141321

Period:
 From 07/01/2012
 To 06/30/2013

Worksheet A-8

Date/Time Prepared:
 11/21/2013 7:10 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.01 CLINIC UTILITIES	B	-94,330	OPERATION OF PLANT	7.00	0	33.01
33.02 ADVERTISING	A	-9,327	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 MISCELLANEOUS INCOME	B	-815	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 CASH OVER/SHORT	B	48	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 NON RHC PHYSICIAN SALARY COSTS	A	-110,235	RURAL HEALTH CLINIC	88.00	0	33.05
33.06 IHA LOBBYING DUES	A	-5,790	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 NON RHC PHYSICIAN FICA	A	-6,674	RURAL HEALTH CLINIC	88.00	0	33.07
33.08 SURGEON BENEFIT OFFSET	A	-3,591	EMPLOYEE BENEFITS	4.00	0	33.08
33.09 NON RHC PHYSICIAN BENEFIT OFFSET	A	-1,190	EMPLOYEE BENEFITS	4.00	0	33.09
33.10 SURGEON FICA OFFSET	A	-12,487	OPERATING ROOM	50.00	0	33.10
33.11 RADIO AND TV ADJUSTMENT	A	-919	OPERATION OF PLANT	7.00	0	33.11
33.12 INTEREST ON CMS LOANS	A	-38,220	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 TELEPHONE COST	A	-10,465	OPERATION OF PLANT	7.00	0	33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,364,162				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8-2

Date/Time Prepared:
11/21/2013 7:10 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	375,584	375,584	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	44,341	44,341	0	0	0	2.00
3.00	60.00	LABORATORY	25,677	25,677	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	38,250	38,250	0	0	0	4.00
5.00	90.00	CLINIC	54,846	54,846	0	0	0	5.00
6.00	91.00	EMERGENCY	1,331,613	374,228	957,385	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,870,311	912,926	957,385			200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	50.00	OPERATING ROOM	0	0	0	375,584	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	44,341	2.00
3.00	60.00	LABORATORY	0	0	0	25,677	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	38,250	4.00
5.00	90.00	CLINIC	0	0	0	54,846	5.00
6.00	91.00	EMERGENCY	0	0	0	374,228	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	912,926	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141321		Period: From 07/01/2012 To 06/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2013 7:10 am	
				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)					241	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)					69	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	514.00	517.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.37	55.78	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)	37.19	37.19	27.89			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)					38,226	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					28,838	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					67,064	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)					67,064	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)					67,064	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)					8,963	24.00
25.00	Assistants (line 4 times column 3, line 11)					1,924	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					10,887	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)					1,705	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					12,592	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)					12,592	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 07/01/2012 To 06/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2013 7:10 am	
		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)	74.37	55.78	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)					67,064		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					12,592		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)					1,128		62.00	
63.00	Total allowance (sum of lines 57-62)					80,784		63.00	
64.00	Total cost of outside supplier services (from your records)					80,131		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					10,887		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,705		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					12,592		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					1,705		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					1,705		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 07/01/2012 To 06/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2013 7:10 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					25	1.00
2.00	Line 1 multiplied by 15 hours per week					375	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					177	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	92.00	91.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.50	52.88	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)	35.25	35.25	26.44			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)					6,486	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					4,812	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					11,298	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)					11,298	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)					61.74	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					23,153	22.00
23.00	Total salary equivalency (see instructions)					23,153	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)					6,239	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)					6,239	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)					974	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					7,213	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)					7,213	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 07/01/2012 To 06/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2013 7:10 am	
				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)	70.50	52.88	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)					23,153	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					7,213	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)					198	62.00
63.00	Total allowance (sum of lines 57-62)					30,564	63.00
64.00	Total cost of outside supplier services (from your records)					19,415	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					6,239	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					974	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					7,213	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					974	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					974	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 07/01/2012 To 06/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2013 7:10 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					44	1.00
2.00	Line 1 multiplied by 15 hours per week					660	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					306	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	377.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.74	0.00	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)	33.87	33.87	0.00			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)					25,538	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)					25,538	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)					25,538	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)					67.74	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					44,708	22.00
23.00	Total salary equivalency (see instructions)					44,708	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)					10,364	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)					10,364	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)					1,683	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					12,047	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)					12,047	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 07/01/2012 To 06/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/21/2013 7:10 am	
						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)	67.74	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)							44,708 57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							12,047 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)							13 62.00	
63.00	Total allowance (sum of lines 57-62)							56,768 63.00	
64.00	Total cost of outside supplier services (from your records)							23,195 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							10,364 100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							1,683 100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27							12,047 100.02	
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							1,683 101.00	
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							1,683 101.02	
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 07/01/2012
To 06/30/2013

Worksheet B
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	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	384,968	384,968			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	184,986		184,986		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	631,950	1,405	0	633,355	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,083,698	38,929	5,403	91,474	2,219,504
6.00 00600	MAINTENANCE & REPAIRS	384,825	15,063	3,224	15,408	418,520
7.00 00700	OPERATION OF PLANT	232,631	47,082	1,903	0	281,616
8.00 00800	LAUNDRY & LINEN SERVICE	69,756	4,139	0	0	73,895
9.00 00900	HOUSEKEEPING	270,037	1,329	0	21,101	292,467
10.00 01000	DIETARY	94,981	27,372	238	5,555	128,146
11.00 01100	CAFETERIA	199,746	0	0	14,556	214,302
13.00 01300	NURSING ADMINISTRATION	428,780	1,873	0	36,174	466,827
16.00 01600	MEDICAL RECORDS & LIBRARY	190,900	5,804	4,842	13,835	215,381
17.00 01700	SOCIAL SERVICE	0	1,361	0	0	1,361
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	764,722	33,144	77,789	51,904	927,559
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	264,740	35,543	26,410	18,983	345,676
53.00 05300	ANESTHESIOLOGY	10,956	570	53	0	11,579
54.00 05400	RADIOLOGY-DIAGNOSTIC	735,430	15,240	35,406	42,081	828,157
60.00 06000	LABORATORY	999,325	8,405	5,333	36,886	1,049,949
65.00 06500	RESPIRATORY THERAPY	297,075	7,493	1,130	21,795	327,493
66.00 06600	PHYSICAL THERAPY	147,334	7,240	105	2,033	156,712
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,354	13,974	105	6,138	126,571
73.00 07300	DRUGS CHARGED TO PATIENTS	470,453	5,886	4,043	15,511	495,893
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,332,035	38,859	10,104	109,826	1,490,824
88.01 08801	RURAL HEALTH CLINIC II	212,677	8,373	8,832	16,445	246,327
90.00 09000	CLINIC	572,470	15,588	0	38,440	626,498
91.00 09100	EMERGENCY	1,724,153	14,082	66	55,618	1,793,919
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
114.00 11400	UTILIZATION REVIEW - SNF					
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,794,982	348,754	184,986	613,763	12,739,176
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	278,464	36,214	0	19,592	334,270
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	13,073,446	384,968	184,986	633,355	13,073,446

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

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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	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,219,504					5.00
6.00	00600	MAINTENANCE & REPAIRS	85,582	504,102				6.00
7.00	00700	OPERATION OF PLANT	57,587	72,013	411,216			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,111	6,331	6,025	101,362		8.00
9.00	00900	HOUSEKEEPING	59,806	2,033	1,935	0	356,241	9.00
10.00	01000	DIETARY	26,204	41,868	39,846	0	0	10.00
11.00	01100	CAFETERIA	43,822	0	0	0	11,223	11.00
13.00	01300	NURSING ADMINISTRATION	95,461	2,865	2,727	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,043	8,877	8,448	0	3,307	16.00
17.00	01700	SOCIAL SERVICE	278	2,081	1,981	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	189,675	50,697	48,248	33,742	67,341	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	70,687	54,366	51,739	10,330	34,271	50.00
53.00	05300	ANESTHESIOLOGY	2,368	871	829	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,348	23,311	22,185	26,318	17,236	54.00
60.00	06000	LABORATORY	214,702	12,856	12,235	0	18,739	60.00
65.00	06500	RESPIRATORY THERAPY	66,968	11,462	10,908	809	14,831	65.00
66.00	06600	PHYSICAL THERAPY	32,046	11,074	10,540	4,500	17,336	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,882	21,375	20,342	0	7,215	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,404	9,003	8,568	0	7,315	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	304,856	59,438	56,565	961	54,814	88.00
88.01	08801	RURAL HEALTH CLINIC II	50,371	12,807	12,189	0	11,524	88.01
90.00	09000	CLINIC	128,111	23,843	22,691	0	12,426	90.00
91.00	09100	EMERGENCY	366,838	21,539	20,499	23,960	51,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,151,150	448,710	358,500	100,620	329,185	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	68,354	55,392	52,716	742	27,056	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,219,504	504,102	411,216	101,362	356,241	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
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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	236,064					10.00
11.00	01100	0	269,347				11.00
13.00	01300	0	18,609	586,489			13.00
16.00	01600	0	11,530	0	291,586		16.00
17.00	01700	0	0	0	0	5,701	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	236,064	36,896	219,953	12,349	5,701	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	12,120	88,237	9,241	0	50.00
53.00	05300	0	0	0	552	0	53.00
54.00	05400	0	25,768	0	82,107	0	54.00
60.00	06000	0	29,656	0	79,792	0	60.00
65.00	06500	0	13,461	80,245	20,634	0	65.00
66.00	06600	0	2,574	0	6,676	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	5,309	0	4,209	0	71.00
73.00	07300	0	5,926	0	19,474	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	50,840	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
90.00	09000	0	17,402	0	8,789	0	90.00
91.00	09100	0	33,223	198,054	47,763	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		236,064	263,314	586,489	291,586	5,701	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	6,033	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		236,064	269,347	586,489	291,586	5,701	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
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 DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,828,225	0	1,828,225
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	676,667	0	676,667
53.00	05300	ANESTHESIOLOGY	0	16,199	0	16,199
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,194,430	0	1,194,430
60.00	06000	LABORATORY	0	1,417,929	0	1,417,929
65.00	06500	RESPIRATORY THERAPY	0	546,811	0	546,811
66.00	06600	PHYSICAL THERAPY	0	241,458	0	241,458
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	210,903	0	210,903
73.00	07300	DRUGS CHARGED TO PATIENTS	0	647,583	0	647,583
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,018,298	0	2,018,298
88.01	08801	RURAL HEALTH CLINIC II	0	333,218	0	333,218
90.00	09000	CLINIC	0	839,760	0	839,760
91.00	09100	EMERGENCY	0	2,557,402	0	2,557,402
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW - SNF				114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	12,528,883	0	12,528,883
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	544,563	0	544,563
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	13,073,446	0	13,073,446

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
11/21/2013 7:10 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		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 DEPARTMENT	0	1,405	0	1,405	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,254	38,929	5,403	48,586	5.00
6.00 00600	MAINTENANCE & REPAIRS	149	15,063	3,224	18,436	6.00
7.00 00700	OPERATION OF PLANT	-197	47,082	1,903	48,788	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,139	0	4,139	8.00
9.00 00900	HOUSEKEEPING	0	1,329	0	1,329	9.00
10.00 01000	DIETARY	0	27,372	238	27,610	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,873	0	1,873	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	5,804	4,842	10,646	16.00
17.00 01700	SOCIAL SERVICE	0	1,361	0	1,361	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,110	33,144	77,789	119,043	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,054	35,543	26,410	63,007	50.00
53.00 05300	ANESTHESIOLOGY	4,218	570	53	4,841	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	75,480	15,240	35,406	126,126	54.00
60.00 06000	LABORATORY	28,835	8,405	5,333	42,573	60.00
65.00 06500	RESPIRATORY THERAPY	6,395	7,493	1,130	15,018	65.00
66.00 06600	PHYSICAL THERAPY	0	7,240	105	7,345	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,974	105	14,079	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	21	5,886	4,043	9,950	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	382	38,859	10,104	49,345	88.00
88.01 08801	RURAL HEALTH CLINIC II	242	8,373	8,832	17,447	88.01
90.00 09000	CLINIC	2	15,588	0	15,590	90.00
91.00 09100	EMERGENCY	5,143	14,082	66	19,291	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW - SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	134,088	348,754	184,986	667,828	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	18,974	36,214	0	55,188	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)	153,062	384,968	184,986	723,016	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
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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	48,789					5.00
6.00	00600	1,881	20,351				6.00
7.00	00700	1,266	2,906	52,960			7.00
8.00	00800	332	256	776	5,503		8.00
9.00	00900	1,315	82	249	0	3,022	9.00
10.00	01000	576	1,690	5,132	0	0	10.00
11.00	01100	963	0	0	0	95	11.00
13.00	01300	2,098	116	351	0	0	13.00
16.00	01600	968	358	1,088	0	28	16.00
17.00	01700	6	84	255	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,169	2,047	6,214	1,832	571	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,554	2,195	6,663	561	291	50.00
53.00	05300	52	35	107	0	0	53.00
54.00	05400	3,723	941	2,857	1,429	146	54.00
60.00	06000	4,720	519	1,576	0	159	60.00
65.00	06500	1,472	463	1,405	44	126	65.00
66.00	06600	704	447	1,357	244	147	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	569	863	2,620	0	61	71.00
73.00	07300	2,229	363	1,103	0	62	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	6,701	2,400	7,286	52	465	88.00
88.01	08801	1,107	517	1,570	0	98	88.01
90.00	09000	2,816	963	2,922	0	105	90.00
91.00	09100	8,065	870	2,640	1,301	438	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		47,286	18,115	46,171	5,463	2,792	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	1,503	2,236	6,789	40	230	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		48,789	20,351	52,960	5,503	3,022	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
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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	35,020					10.00
11.00	01100	0	1,090				11.00
13.00	01300	0	75	4,593			13.00
16.00	01600	0	47	0	13,166		16.00
17.00	01700	0	0	0	0	1,706	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	35,020	149	1,723	557	1,706	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	49	691	417	0	50.00
53.00	05300	0	0	0	25	0	53.00
54.00	05400	0	104	0	3,710	0	54.00
60.00	06000	0	120	0	3,602	0	60.00
65.00	06500	0	54	628	932	0	65.00
66.00	06600	0	10	0	301	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	21	0	190	0	71.00
73.00	07300	0	24	0	879	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	209	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
90.00	09000	0	70	0	397	0	90.00
91.00	09100	0	134	1,551	2,156	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		35,020	1,066	4,593	13,166	1,706	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	24	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		35,020	1,090	4,593	13,166	1,706	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet B Part II Date/Time Prepared: 11/21/2013 7:10 am
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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		19.00	24.00	25.00	26.00		
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 DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
6.00	00600	MAINTENANCE & REPAIRS				6.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE				17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0			19.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		173,146	0	173,146	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		75,470	0	75,470	50.00
53.00	05300	ANESTHESIOLOGY		5,060	0	5,060	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		139,129	0	139,129	54.00
60.00	06000	LABORATORY		53,351	0	53,351	60.00
65.00	06500	RESPIRATORY THERAPY		20,190	0	20,190	65.00
66.00	06600	PHYSICAL THERAPY		10,560	0	10,560	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		18,417	0	18,417	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		14,644	0	14,644	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		66,704	0	66,704	88.00
88.01	08801	RURAL HEALTH CLINIC II		20,775	0	20,775	88.01
90.00	09000	CLINIC		22,948	0	22,948	90.00
91.00	09100	EMERGENCY		36,569	0	36,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	656,963	0	656,963	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES		66,053	0	66,053	192.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	723,016	0	723,016	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (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		179,322			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	222	0	6,717,682		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,151	5,238	970,215	-2,219,504	10,853,942
6.00 00600	MAINTENANCE & REPAIRS	2,380	3,125	163,422	0	418,520
7.00 00700	OPERATION OF PLANT	7,439	1,845	0	0	281,616
8.00 00800	LAUNDRY & LINEN SERVICE	654	0	0	0	73,895
9.00 00900	HOUSEKEEPING	210	0	223,810	0	292,467
10.00 01000	DIETARY	4,325	231	58,922	0	128,146
11.00 01100	CAFETERIA	0	0	154,393	0	214,302
13.00 01300	NURSING ADMINISTRATION	296	0	383,679	0	466,827
16.00 01600	MEDICAL RECORDS & LIBRARY	917	4,694	146,738	0	215,381
17.00 01700	SOCIAL SERVICE	215	0	0	0	1,361
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,237	75,406	550,516	0	927,559
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,616	25,601	201,348	0	345,676
53.00 05300	ANESTHESIOLOGY	90	51	0	0	11,579
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,408	34,322	446,327	0	828,157
60.00 06000	LABORATORY	1,328	5,170	391,226	0	1,049,949
65.00 06500	RESPIRATORY THERAPY	1,184	1,095	231,165	0	327,493
66.00 06600	PHYSICAL THERAPY	1,144	102	21,566	0	156,712
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,208	102	65,106	0	126,571
73.00 07300	DRUGS CHARGED TO PATIENTS	930	3,919	164,517	0	495,893
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	6,140	9,795	1,164,888	0	1,490,824
88.01 08801	RURAL HEALTH CLINIC II	1,323	8,562	174,419	0	246,327
90.00 09000	CLINIC	2,463	0	407,717	0	626,498
91.00 09100	EMERGENCY	2,225	64	589,906	0	1,793,919
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW - SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,105	179,322	6,509,880	-2,219,504	10,519,672
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,722	0	207,802	0	334,270
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)	384,968	184,986	633,355		2,219,504
203.00	Unit cost multiplier (Wkst. B, Part I)	6.328900	1.031586	0.094282		0.204488
204.00	Cost to be allocated (per Wkst. B, Part II)			1,405		48,789
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000209		0.004495

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	52,074					6.00
7.00	00700	7,439	44,635				7.00
8.00	00800	654	654	57,915			8.00
9.00	00900	210	210	0	3,555		9.00
10.00	01000	4,325	4,325	0	0	5,599	10.00
11.00	01100	0	0	0	112	0	11.00
13.00	01300	296	296	0	0	0	13.00
16.00	01600	917	917	0	33	0	16.00
17.00	01700	215	215	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,237	5,237	19,280	672	5,599	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,616	5,616	5,902	342	0	50.00
53.00	05300	90	90	0	0	0	53.00
54.00	05400	2,408	2,408	15,037	172	0	54.00
60.00	06000	1,328	1,328	0	187	0	60.00
65.00	06500	1,184	1,184	462	148	0	65.00
66.00	06600	1,144	1,144	2,571	173	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	2,208	2,208	0	72	0	71.00
73.00	07300	930	930	0	73	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	6,140	6,140	549	547	0	88.00
88.01	08801	1,323	1,323	0	115	0	88.01
90.00	09000	2,463	2,463	0	124	0	90.00
91.00	09100	2,225	2,225	13,690	515	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		46,352	38,913	57,491	3,285	5,599	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	5,722	5,722	424	270	0	192.00
200.00							200.00
201.00							201.00
202.00		504,102	411,216	101,362	356,241	236,064	202.00
203.00		9.680493	9.212860	1.750186	100.208439	42.161815	203.00
204.00		20,351	52,960	5,503	3,022	35,020	204.00
205.00		0.390809	1.186513	0.095019	0.850070	6.254688	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

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Date/Time Prepared:
11/21/2013 7:10 am

Cost Center Description		CAFETERIA (FTE)	NURSING ADMINISTRATION (DIRECT NURS. HRS. FTE)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		11.00	13.00	16.00	17.00	19.00	
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	10,045					11.00
13.00	01300	694	3,669				13.00
16.00	01600	430	0	26,117,370			16.00
17.00	01700	0	0	0	100		17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,376	1,376	1,106,144	100		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	452	552	827,786	0	0	50.00
53.00	05300	0	0	49,476	0	0	53.00
54.00	05400	961	0	7,353,468	0	0	54.00
60.00	06000	1,106	0	7,147,303	0	0	60.00
65.00	06500	502	502	1,848,280	0	0	65.00
66.00	06600	96	0	597,966	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	198	0	377,042	0	0	71.00
73.00	07300	221	0	1,744,327	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,896	0	0	0	0	88.00
88.01	08801	0	0	0	0	0	88.01
90.00	09000	649	0	787,257	0	0	90.00
91.00	09100	1,239	1,239	4,278,321	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		9,820	3,669	26,117,370	100	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	225	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		269,347	586,489	291,586	5,701	0	202.00
203.00		26.814037	159.849823	0.011164	57.010000	0.000000	203.00
204.00		1,090	4,593	13,166	1,706	0	204.00
205.00		0.108512	1.251840	0.000504	17.060000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/21/2013 7:10 am

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	1,828,225		1,828,225	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	676,667		676,667	0	0	50.00
53.00	05300	ANESTHESIOLOGY	16,199		16,199	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,194,430		1,194,430	0	0	54.00
60.00	06000	LABORATORY	1,417,929		1,417,929	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	546,811	0	546,811	0	0	65.00
66.00	06600	PHYSICAL THERAPY	241,458	0	241,458	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	210,903		210,903	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	647,583		647,583	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,018,298		2,018,298	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	333,218		333,218	0	0	88.01
90.00	09000	CLINIC	839,760		839,760	0	0	90.00
91.00	09100	EMERGENCY	2,557,402		2,557,402	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	276,963		276,963	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW - SNF						114.00
200.00		Subtotal (see instructions)	12,805,846	0	12,805,846	0	0	200.00
201.00		Less Observation Beds	276,963		276,963		0	201.00
202.00		Total (see instructions)	12,528,883	0	12,528,883	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/21/2013 7:10 am

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	900,620		900,620		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,510	819,276	827,786	0.817442	50.00
53.00	05300	ANESTHESIOLOGY	372	49,104	49,476	0.327411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,638	7,120,830	7,353,468	0.162431	54.00
60.00	06000	LABORATORY	411,847	6,735,456	7,147,303	0.198387	60.00
65.00	06500	RESPIRATORY THERAPY	345,522	1,502,758	1,848,280	0.295849	65.00
66.00	06600	PHYSICAL THERAPY	168,921	429,045	597,966	0.403799	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,758	194,284	377,042	0.559362	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506,408	1,237,919	1,744,327	0.371251	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,286,571	1,286,571		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	161,550	161,550		88.01
90.00	09000	CLINIC	0	787,257	787,257	1.066691	90.00
91.00	09100	EMERGENCY	72,713	4,205,608	4,278,321	0.597758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	205,524	205,524	1.347594	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW - SNF					114.00
200.00		Subtotal (see instructions)	2,830,309	24,735,182	27,565,491		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,830,309	24,735,182	27,565,491		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/21/2013 7:10 am

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	05300 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
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
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 II				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
114.00	11400 UTILIZATION REVIEW - SNF				114.00
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 07/01/2012 To 06/30/2013		Worksheet D Part II Date/Time Prepared: 11/21/2013 7:10 am	
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	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	75,470	827,786	0.091171	8,510	776	50.00
53.00	05300	ANESTHESIOLOGY	5,060	49,476	0.102272	372	38	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,129	7,353,468	0.018920	109,129	2,065	54.00
60.00	06000	LABORATORY	53,351	7,147,303	0.007464	263,745	1,969	60.00
65.00	06500	RESPIRATORY THERAPY	20,190	1,848,280	0.010924	278,432	3,042	65.00
66.00	06600	PHYSICAL THERAPY	10,560	597,966	0.017660	81,309	1,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,417	377,042	0.048846	147,462	7,203	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,644	1,744,327	0.008395	360,213	3,024	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	66,704	1,286,571	0.051846	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	20,775	161,550	0.128598	0	0	88.01
90.00	09000	CLINIC	22,948	787,257	0.029149	0	0	90.00
91.00	09100	EMERGENCY	36,569	4,278,321	0.008548	1,641	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	205,524	0.000000	0	0	92.00
200.00		Total (Lines 50-199)	483,817	26,664,871		1,250,813	19,567	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
11/21/2013 7:10 am

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col . 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
11/21/2013 7:10 am

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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	827,786	0.000000	0.000000	8,510	50.00
53.00	05300	ANESTHESIOLOGY	0	49,476	0.000000	0.000000	372	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,353,468	0.000000	0.000000	109,129	54.00
60.00	06000	LABORATORY	0	7,147,303	0.000000	0.000000	263,745	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,848,280	0.000000	0.000000	278,432	65.00
66.00	06600	PHYSICAL THERAPY	0	597,966	0.000000	0.000000	81,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	377,042	0.000000	0.000000	147,462	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,744,327	0.000000	0.000000	360,213	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,286,571	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	161,550	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	787,257	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	4,278,321	0.000000	0.000000	1,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	205,524	0.000000	0.000000	0	92.00
200.00		Total (Lines 50-199)	0	26,664,871			1,250,813	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/21/2013 7:10 am
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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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 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
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
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 II	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 07/01/2012
To 06/30/2013

Worksheet D
Part V
Date/Time Prepared:
11/21/2013 7:10 am

Title XVIII		Hospital		Cost		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.817442	0	456,640	0	0
53.00	05300 ANESTHESIOLOGY	0.327411	0	22,692	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162431	0	2,299,858	0	0
60.00	06000 LABORATORY	0.198387	0	2,408,152	50	0
65.00	06500 RESPIRATORY THERAPY	0.295849	0	817,827	0	0
66.00	06600 PHYSICAL THERAPY	0.403799	0	177,640	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.559362	0	99,526	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.371251	0	558,583	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0
88.01	08801 RURAL HEALTH CLINIC II	0.000000				0
90.00	09000 CLINIC	1.066691	0	765,112	0	0
91.00	09100 EMERGENCY	0.597758	0	1,271,857	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.347594	0	111,552	0	0
200.00	Subtotal (see instructions)		0	8,989,439	50	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	8,989,439	50	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/21/2013 7:10 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	373,277	0	50.00
53.00	05300 ANESTHESIOLOGY	7,430	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	373,568	0	54.00
60.00	06000 LABORATORY	477,746	10	60.00
65.00	06500 RESPIRATORY THERAPY	241,953	0	65.00
66.00	06600 PHYSICAL THERAPY	71,731	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	55,671	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	207,374	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	88.01
90.00	09000 CLINIC	816,138	0	90.00
91.00	09100 EMERGENCY	760,263	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	150,327	0	92.00
200.00	Subtotal (see instructions)	3,535,478	10	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,535,478	10	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141321

Period:

Worksheet D

Component CCN: 14Z321

From 07/01/2012

Part V

To 06/30/2013

Date/Time Prepared:

11/21/2013 7:10 am

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.817442	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.327411	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.162431	0	0	0	0
60.00 06000 LABORATORY	0.198387	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.295849	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.403799	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.559362	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.371251	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
88.01 08801 RURAL HEALTH CLINIC II	0.000000				0
90.00 09000 CLINIC	1.066691	0	0	0	0
91.00 09100 EMERGENCY	0.597758	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.347594	0	0	0	0
200.00 Subtotal (see instructions)		0	0	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141321 Component CCN: 14Z321	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/21/2013 7:10 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		88.01
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	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		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/21/2013 7:10 am
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)		1,203	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,022	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)		841	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		67	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)		105	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		9	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)		675	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)		67	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)		105	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		132.03	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		132.03	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,828,225	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)		1,188	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)		264,379	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,563,846	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	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)		0.00	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)		1,563,846	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)		1,530.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,032,872	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)		1,032,872	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141321		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 11/21/2013 7:10 am	
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)		
	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)					409,529		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,442,401		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)					102,522		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					160,669		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					263,191		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)						181	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,530.18	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						276,963	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141321		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/21/2013 7:10 am	
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 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/21/2013 7:10 am	
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		670,730		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.817442	8,510	6,956	50.00
53.00	05300 ANESTHESIOLOGY	0.327411	372	122	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162431	109,129	17,726	54.00
60.00	06000 LABORATORY	0.198387	263,745	52,324	60.00
65.00	06500 RESPIRATORY THERAPY	0.295849	278,432	82,374	65.00
66.00	06600 PHYSICAL THERAPY	0.403799	81,309	32,832	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.559362	147,462	82,485	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.371251	360,213	133,729	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	1.066691	0	0	90.00
91.00	09100 EMERGENCY	0.597758	1,641	981	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.347594	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,250,813	409,529	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)		1,250,813		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3	
		Component CCN: 14Z321		Date/Time Prepared: 11/21/2013 7:10 am	
		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	0.817442	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.327411	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.162431	3,822	621	54.00
60.00	06000 LABORATORY	0.198387	19,223	3,814	60.00
65.00	06500 RESPIRATORY THERAPY	0.295849	12,799	3,787	65.00
66.00	06600 PHYSICAL THERAPY	0.403799	75,121	30,334	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.559362	16,318	9,128	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.371251	49,770	18,477	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	1.066691	0	0	90.00
91.00	09100 EMERGENCY	0.597758	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.347594	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		177,053	66,161	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)		177,053		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/21/2013 7:10 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,535,488 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)			3,535,488 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)			3,570,843 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)			28,994 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,310,944 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)			2,230,905 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)			2,230,905 30.00
31.00	Primary payer payments			255 31.00
32.00	Subtotal (line 30 minus line 31)			2,230,650 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)			467,232 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			467,232 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			397,182 36.00
37.00	Subtotal (see instructions)			2,697,882 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00				0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,697,882 40.00
40.01	Sequestration adjustment (see instructions)			13,489 40.01
41.00	Interim payments			2,423,751 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			260,642 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 07/01/2012
To 06/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
11/21/2013 7:10 am

		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		1,262,238		2,338,978	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	05/16/2013	152,814	05/16/2013	169,406	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	01/10/2013	1,294	01/10/2013	52,879	3.50	
3.51		04/24/2013	4,049	04/24/2013	31,754	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)		147,471		84,773	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)		1,409,709		2,423,751	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		274,131	6.01	
6.02	SETTLEMENT TO PROGRAM		67,299		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,342,410		2,697,882	7.00	
				Contractor Number	NPR 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 07/01/2012
To 06/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
11/21/2013 7:10 am

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		327,194		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	01/10/2013	2,151		0	3.50
3.51			0		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)		-2,151		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)		325,043		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		802		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		325,845		0	7.00
				Contractor Number	NPR 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 07/01/2012
To 06/30/2013

Worksheet E-1
Part II
Date/Time Prepared:
11/21/2013 7:10 am

		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			296 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			675 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			841 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			27,565,491 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			467,509 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			450,715 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			450,715 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			450,715 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			414,432 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			36,283 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141321 Component CCN: 14Z321	Period: From 07/01/2012 To 06/30/2013	Worksheet E-2 Date/Time Prepared: 11/21/2013 7:10 am
		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)	265,823	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)	66,823	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	172	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)	332,646	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	332,646	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)	332,646	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	6,801	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)	325,845	0	15.00
16.00		0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	325,845	0	19.00
19.01	Sequestration adjustment (see instructions)	1,629	0	19.01
20.00	Interim payments	325,043	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	-827	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/21/2013 7:10 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		1,442,401	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)		1,442,401	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,456,825	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)		1,456,825	19.00
20.00	Deductibles (exclude professional component)		156,808	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		1,300,017	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,300,017	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		42,393	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		42,393	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		32,392	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,342,410	28.00
29.00			0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		1,342,410	30.00
30.01	Sequestration adjustment (see instructions)		6,712	30.01
31.00	Interim payments		1,409,709	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32		-74,011	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 07/01/2012 To 06/30/2013 Worksheet G Date/Time Prepared: 11/21/2013 7:10 am

		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	1,131,958	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	2,538,565	0	0	0	4.00
5.00	Other receivable	1,245,981	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	195,701	0	0	0	7.00
8.00	Prepaid expenses	61,603	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)	5,173,808	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	-95,310	0	0	0	14.00
15.00	Buildings	4,557,832	0	0	0	15.00
16.00	Accumulated depreciation	-4,451,118	0	0	0	16.00
17.00	Leasehold improvements	4,607,742	0	0	0	17.00
18.00	Accumulated depreciation	-3,952,023	0	0	0	18.00
19.00	Fixed equipment	6,425,981	0	0	0	19.00
20.00	Accumulated depreciation	-5,656,523	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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	494,059	0	0	0	27.00
28.00	Accumulated depreciation	-60,745	0	0	0	28.00
29.00	Minor equipment-nondepreciable	41,279	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,033,354	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	1,630,260	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,630,260	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,837,422	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,922,426	0	0	0	37.00
38.00	Salaries, wages, and fees payable	718,168	0	0	0	38.00
39.00	Payroll taxes payable	96,950	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	818,285	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)	3,555,829	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	443,881	0	0	0	47.00
48.00	Unsecured loans	856,500	0	0	0	48.00
49.00	Other long term liabilities	3,679,815	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,980,196	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,536,025	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	301,397	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)	301,397	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,837,422	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-1

Date/Time Prepared:
11/21/2013 7:10 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-634,941		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		574,646				2.00
3.00	Total (sum of line 1 and line 2)		-60,295		0		3.00
4.00	OTHER MISCELLANEOUS	361,692		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		361,692		0		10.00
11.00	Subtotal (line 3 plus line 10)		301,397		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		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)		301,397		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	OTHER MISCELLANEOUS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			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)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/21/2013 7:10 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	833,824		833,824	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	66,796		66,796	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)	900,620		900,620	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)	900,620		900,620	17.00
18.00	Ancillary services	1,929,689	18,113,560	20,043,249	18.00
19.00	Outpatient services	0	4,411,132	4,411,132	19.00
20.00	RURAL HEALTH CLINIC	0	2,054,234	2,054,234	20.00
20.01	RURAL HEALTH CLINIC II	0	156,254	156,254	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	20,387	2,241,566	2,261,953	27.00
27.01	SENIOR CARE	0	111,305	111,305	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,850,696	27,088,051	29,938,747	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,437,608		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)		14,437,608		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141321

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-3

Date/Time Prepared:
11/21/2013 7:10 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	29,938,747	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,643,386	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,295,361	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,437,608	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,142,247	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	80,874	6.00
7.00	Income from investments	24,910	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	1,892	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	49,132	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	0	16.00
17.00	Revenue from sale of drugs to other than patients	1,570	17.00
18.00	Revenue from sale of medical records and abstracts	8,669	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	20,350	22.00
23.00	Governmental appropriations	775,241	23.00
24.00	EHR INCENTIVE AND OTHER INCOME	754,255	24.00
25.00	Total other income (sum of lines 6-24)	1,716,893	25.00
26.00	Total (line 5 plus line 25)	574,646	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)	574,646	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2012 To 06/30/2013	Worksheet M-1 Date/Time Prepared: 11/21/2013 7:10 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	521,131	30,696	551,827	12,927	564,754	1.00
2.00	Physician Assistant	96,299	6,645	102,944	0	102,944	2.00
3.00	Nurse Practitioner	228,242	13,724	241,966	4,128	246,094	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	293,360	17,909	311,269	0	311,269	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)	1,139,032	68,974	1,208,006	17,055	1,225,061	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	13,099	13,099	0	13,099	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	1,542	1,542	0	1,542	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	14,641	14,641	0	14,641	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,139,032	83,615	1,222,647	17,055	1,239,702	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	48,120	48,120	0	48,120	29.00
30.00	Administrative Costs	120,167	40,955	161,122	0	161,122	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	120,167	89,075	209,242	0	209,242	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,259,199	172,690	1,431,889	17,055	1,448,944	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2012 To 06/30/2013	Worksheet M-1 Date/Time Prepared: 11/21/2013 7:10 am
		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	-116,909	447,845	1.00
2.00	Physician Assistant	0	102,944	2.00
3.00	Nurse Practitioner	0	246,094	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	311,269	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)	-116,909	1,108,152	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	13,099	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	1,542	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	14,641	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-116,909	1,122,793	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	48,120	29.00
30.00	Administrative Costs	0	161,122	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	209,242	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-116,909	1,332,035	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141321 Component CCN: 148510	Period: From 07/01/2012 To 06/30/2013	Worksheet M-1 Date/Time Prepared: 11/21/2013 7:10 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) II Reclassifications	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	0	0	0	29,977	29,977	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	90,714	0	90,714	-4,434	86,280	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	31,940	0	31,940	0	31,940	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)	122,654	0	122,654	25,543	148,197	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	5,149	5,149	0	5,149	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	991	991	0	991	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	6,140	6,140	0	6,140	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	122,654	6,140	128,794	25,543	154,337	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	22,328	22,328	-5,351	16,977	29.00
30.00	Administrative Costs	27,626	13,737	41,363	0	41,363	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	27,626	36,065	63,691	-5,351	58,340	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	150,280	42,205	192,485	20,192	212,677	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141321 Component CCN: 148510	Period: From 07/01/2012 To 06/30/2013	Worksheet M-1 Date/Time Prepared: 11/21/2013 7:10 am
		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	0	29,977
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	86,280
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	31,940
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	148,197
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	0
15.00	Medical Supplies	0	5,149
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	991
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	6,140
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	154,337
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	16,977
30.00	Administrative Costs	0	41,363
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	58,340
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	212,677

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES				Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2012 To 06/30/2013	Worksheet M-2 Date/Time Prepared: 11/21/2013 7:10 am	
					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	1.51	3,982	4,200	6,342	1.00	
2.00	Physician Assistant	0.78	2,082	2,100	1,638	2.00	
3.00	Nurse Practitioner	2.15	5,355	2,100	4,515	3.00	
4.00	Subtotal (sum of lines 1-3)	4.44	11,419		12,495	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)	4.44	11,419		12,495	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)					1,122,793	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)					1,122,793	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)					209,242	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					686,263	15.00
16.00	Total overhead (sum of lines 14 and 15)					895,505	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					895,505	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					895,505	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,018,298	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141321	Period: From 07/01/2012	Worksheet M-2		
		Component CCN: 148510	To 06/30/2013	Date/Time Prepared: 11/21/2013 7:10 am		
			Rural Health Clinic (RHC) II	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	0.14	204	4,200	588	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.76	1,012	2,100	1,596	3.00
4.00	Subtotal (sum of lines 1-3)	0.90	1,216		2,184	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)	0.90	1,216		2,184	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)				154,337	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)				154,337	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)				58,340	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				120,541	15.00
16.00	Total overhead (sum of lines 14 and 15)				178,881	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				178,881	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				178,881	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				333,218	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141321	Period: From 07/01/2012 To 06/30/2013	Worksheet M-3
		Component CCN: 143469		Date/Time Prepared: 11/21/2013 7:10 am
		Title XVIII	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)		2,018,298	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		7,371	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,010,927	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		12,495	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)		12,495	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		160.94	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. 100-04, chapter 9, §20.6 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	160.94	160.94	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,283	1,284	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	206,486	206,647	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	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		413,133	16.00
16.01	Total program charges (see instructions)(from contractor's records)		279,197	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,333	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,972	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.)		299,718	16.04
16.05	Total program cost (see instructions)		301,690	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		36,513	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		48,270	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		301,690	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,740	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		307,430	22.00
23.00	Allowable bad debts (see instructions)		16,167	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,167	24.00
25.00	Net reimbursable amount (see instructions)		0	25.00
26.00	Sequestration adjustment (see instructions)		323,597	26.00
26.01	Sequestration adjustment (see instructions)		1,618	26.01
27.00	Interim payments		259,234	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		62,745	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 07/01/2012 To 06/30/2013	Worksheet M-3
		Component CCN: 148510		Date/Time Prepared: 11/21/2013 7:10 am
		Title XVIIII	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)		333,218	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		460	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		332,758	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,184	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)		2,184	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		152.36	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. 100-04, chapter 9, §20.6 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	152.36	152.36	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	61	62	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	9,294	9,446	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	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		18,740	16.00
16.01	Total program charges (see instructions)(from contractor's records)		12,845	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.)		14,264	16.04
16.05	Total program cost (see instructions)		14,264	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		910	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		2,387	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		14,264	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		460	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		14,724	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	Net reimbursable amount (see instructions)		0	25.00
26.00	Net reimbursable amount (see instructions)		14,724	26.00
26.01	Sequestration adjustment (see instructions)		74	26.01
27.00	Interim payments		18,018	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		-3,368	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 07/01/2012
To 06/30/2013

Worksheet M-4
Date/Time Prepared:
11/21/2013 7:10 am

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)	1,108,152	1,108,152	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000256	0.000736	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	284	816	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	775	2,226	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,059	3,042	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,122,793	1,122,793	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	895,505	895,505	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000943	0.002709	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	844	2,426	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,903	5,468	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	63	181	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	30.21	30.21	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	58	132	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,752	3,988	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)		7,371	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)		5,740	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141321
Component CCN: 148510

Period:
From 07/01/2012
To 06/30/2013

Worksheet M-4
Date/Time Prepared:
11/21/2013 7:10 am

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)	148,197	148,197	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000361	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	53	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	160	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	213	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	154,337	154,337	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	178,881	178,881	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001380	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	247	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	460	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	13	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	35.38	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	13	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	460	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)		460	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)		460	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 07/01/2012 To 06/30/2013	Worksheet M-5 Date/Time Prepared: 11/21/2013 7:10 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		296,736	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			0	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		01/10/2013	33,694	3.50
3.51		04/24/2013	3,808	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)		-37,502	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		259,234	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		64,363	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		323,597	7.00
		Contractor Number	NPR 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 07/01/2012 To 06/30/2013	Worksheet M-5 Date/Time Prepared: 11/21/2013 7:10 am
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		18,467	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			0	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		01/10/2013	449	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)		-449	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		18,018	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		3,294	6.02
7.00	Total Medicare program liability (see instructions)		14,724	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00