IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 11/19/2010 15:59
FORM APPROVED
OMB NO. 0938-0050

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

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1321	PERIOD FROM 7/ 1/2009 TO 6/30/2010	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 11/19/2010 TIME 15:59

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
FRANKLIN HOSPITAL 14-1321
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING 6/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 11/19/2010 TIME 15:59

LvCjJvyQrzznprIqfmDEX0aw9kfv4O
gnVt60QRcLGV5AS72jRGjhLx9:yjUy
V8.90SskvL0qHynT

PI ENCRYPTION INFORMATION
DATE: 11/19/2010 TIME 15:59

---

vCMdt:2A4DE9tHTz4OON4FSQb.jjE0
0dn7s0MNtbzHru9CAUnGpgJW1rbBSi
2t4Y3wtLQZ08VBZ9

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1	HOSPITAL	0	45,722	-79,212	0	
3	SWING BED - SNF	0	20,643	0	0	
9	RHC	0	0	13,939	0	
9 .01	RHC II	0	0	10,624	0	
100	TOTAL	0	66,365	-54,649	0	

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

IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 11/19/2010 15:59
FORM APPROVED
OMB NO. 0938-0050

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

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1321	PERIOD FROM 7/ 1/2009 TO 6/30/2010	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / /	INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 11/19/2010 TIME 15:59

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
FRANKLIN HOSPITAL 14-1321
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING 6/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			A	B		
		1	2	3	4	
1	HOSPITAL	0	45,722	-79,212		0
3	SWING BED - SNF	0	20,643	0		0
9	RHC	0	0	13,939		0
9 .01	RHC II	0	0	10,624		0
100	TOTAL	0	66,365	-54,649		0

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER NO: 14-1321 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/19/2010 WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 201 BAILEY LANE P.O. BOX:
1.01 CITY: BENTON STATE: IL ZIP CODE: 62812- COUNTY: FRANKLIN

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	FRANKLIN HOSPITAL	14-1321		8/ 1/2002	N	O	N
04.00	SWING BED - SNF	FRANKLIN HOSP SWING BED	14-Z321		8/ 1/2002	N	O	N
14.00	HOSPITAL-BASED RHC	FRANKLIN RHC	14-3469		7/ 6/2005	N	O	N
14.01	HOSPITAL-BASED RHC 2	WEST FRANKFORT RHC II	14-8510		4/24/2010	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2009 TO: 6/30/2010

		1	2
18	TYPE OF CONTROL	2	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1
20	SUBPROVIDER	

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.				
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.	N			
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).				
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	N		Y
21.04	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2			
21.05	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2			
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO.	N			
21.07	DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS). IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS)	N	N		
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.				
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	N			
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.	N			
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.		/ /		/ /
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /
24	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY)				/ /
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).				/ /

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N	
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?		
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.		
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.		
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N	
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)		
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)		
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	/ /	
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	/ /	
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	8/ 1/2002
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02		

		1	2	3	4
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	0	0.0000	0.0000	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0		

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

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

29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N	
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y	
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N	
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N	
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N	
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N	
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N	

MISCELLANEOUS COST REPORT INFORMATION

32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N	
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N	
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N	
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N	

		V	XVIII	XIX
	PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	1	2	3
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N
	TITLE XIX INPATIENT SERVICES			
38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	Y		
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	N		
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	N		
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	N		
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	N		
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).	N		
40.01	NAME: FI/CONTRACTOR NAME			FI/CONTRACTOR #
40.02	STREET: P.O. BOX:			
40.03	CITY: STATE: ZIP CODE: -			
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y		
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N		
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N		
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000	
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?			
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?			
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?			
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).			

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

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

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		
	PREMIUMS: 0		
	PAID LOSSES: 0		
	AND/OR SELF INSURANCE: 0		
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

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

57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?	N
58	ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YDU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS DPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.	N
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING DN OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).	0
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FDR NO. (SEE INSTRUCTIONS)	N
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N
60.01	IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MDST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FDR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC).	0

MULTICAMPUS

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

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

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). / /

HDSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET S-3 I PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS -------- TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	25	9,125	100.00		844		80
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					171		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	25	9,125	100.00		1,015		80
12	TOTAL	25	9,125	100.00		1,015		80
13	RPCH VISITS							
24	RURAL HEALTH CLINIC					2,905		
24 01	RURAL HEALTH CLINIC 2					27		
25	TOTAL	25						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / TITLE XIX ADMITTED 5.01	OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	TRIPS TOTAL OBSERVATIDN BEDS ADMITTED 6.01	NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			1,051				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			171				
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			1,222				
12	TOTAL			1,222				
13	RPCH VISITS							
24	RURAL HEALTH CLINIC			11,222				
24 01	RURAL HEALTH CLINIC 2			181				
25	TOTAL							
26	OBSERVATION BED DAYS			181		181		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV --- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					254	33	337
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		228.31			254	33	337
13	RPCH VISITS							
24	RURAL HEALTH CLINIC		16.22					
24 01	RURAL HEALTH CLINIC 2		2.80					
25	TDTAL		247.33					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET S-8
COMPONENT NO:	TO 6/30/2010	
14-3469		

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 201 BAILEY LANE

1.01 CITY: BENTON STATE: IL ZIP CODE: 62812 COUNTY: FRANKLIN

2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD 1	DATE 2
3	COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)		/ /
4	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /
5	HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT)		/ /
6	APPALACHIAN REGIONAL COMMISSION		/ /
7	LOOK-ALIKES		/ /
8	OTHER (SPECIFY)		/ /

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NUMBER
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		

		PHYSICIAN NAME	HOURS OF SUPERVISION
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.) N

FACILITY HOURS OF OPERATIONS (1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	TYPE OPERATION	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC	900	2200	900	2200	900	2200	900	2200	900	2200	900	2200	900	2200

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES.

15 PROVIDER NAME: PROVIDER NUMBER:

		TITLE V	TITLE XVIII	TITLE XIX
16	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.			
17	HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.			

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

PROVIDER NO:	14-1321	PERIOD:	PREPARED 11/19/2010
FROM	7/ 1/2009		WORKSHEET S-8
TO	6/30/2010		
COMPONENT NO:	14-8510		

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 201 BAILEY LANE

1.01 CITY: BENTON STATE: IL ZIP CODE: 62812 COUNTY: FRANKLIN

2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD 1	DATE 2
3	COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)		/ /
4	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /
5	HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT)		/ /
6	APPALACHIAN REGIONAL COMMISSION		/ /
7	LOOK-ALIKES		/ /
8	OTHER (SPECIFY)		/ /

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NUMBER
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		

		PHYSICIAN NAME	HOURS OF SUPERVISION
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.) N

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM	SUNDAY TO	MONDAY FROM	MONDAY TO	TUESDAY FROM	TUESDAY TO	WEDNESDAY FROM	WEDNESDAY TO	THURSDAY FROM	THURSDAY TO	FRIDAY FROM	FRIDAY TO	SATURDAY FROM	SATURDAY TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC	900	2200	900	2200	900	2200	900	2200	900	2200	900	2200	900	2200

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES.

15 PROVIDER NAME: PROVIDER NUMBER:

		TITLE V	TITLE XVIII	TITLE XIX
16	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.			
17	HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.			

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		371,995	371,995		371,995
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		376,695	376,695	21,788	398,483
5	0500	EMPLOYEE BENEFITS	48,308	1,320,891	1,369,199		1,369,199
6	0600	ADMINISTRATIVE & GENERAL	965,614	1,124,350	2,089,964	311,443	2,401,407
7	0700	MAINTENANCE & REPAIRS	216,475	231,196	447,671		447,671
8	0800	OPERATION OF PLANT		385,833	385,833		385,833
9	0900	LAUNDRY & LINEN SERVICE		62,534	62,534		62,534
10	1000	HOUSEKEEPING	175,490	17,723	193,213		193,213
11	1100	DIETARY	368,077	313,404	681,481	-122,165	559,316
12	1200	CAFETERIA				122,165	122,165
14	1400	NURSING ADMINISTRATION	358,457	3,846	362,303		362,303
17	1700	MEDICAL RECORDS & LIBRARY	137,217	41,901	179,118		179,118
18	1800	SOCIAL SERVICE					
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	617,063	42,321	659,384	-21,645	637,739
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	144,621	62,818	207,439	-15,098	192,341
40	4000	ANESTHESIOLOGY		52,095	52,095	-5,368	46,727
41	4100	RADIOLOGY-DIAGNOSTIC	447,398	256,429	703,827	-23,176	680,651
44	4400	LABORATORY	382,583	494,638	877,221	-256,700	620,521
49	4900	RESPIRATORY THERAPY	235,105	77,465	312,570	-12,034	300,536
50	5000	PHYSICAL THERAPY	11,866	197,228	209,094	-1,762	207,332
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,728	21,093	87,821	393,033	480,854
56	5600	DRUGS CHARGED TO PATIENTS	139,371	374,432	513,803	-1,336	512,467
59	3020	OP PSYCH	208,866	173,467	382,333	-3,135	379,198
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	3,389	1,574	4,963	-30	4,933
61	6100	EMERGENCY	588,839	1,482,404	2,071,243	-35,913	2,035,330
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC	1,058,212	107,078	1,165,290	-15,372	1,149,918
63.51	6311	RURAL HEALTH CLINIC 2	35,310	12,535	47,845	-368	47,477
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		333,231	333,231	-333,231	
95		SUBTOTALS	6,208,989	7,939,176	14,148,165	1,096	14,149,261
		NONREIMBURS COST CENTERS					
100	7954	OTHER NONREIMBURSABLE COST CENTERS					
100.01	7951	UNASSIGNED SPACE					
100.02	7952	LEASED CLINICS	88,212	24,876	113,088	-786	112,302
100.03	7953	MARKETING	54,683	25,188	79,871	-310	79,561
101		TOTAL	6,351,884	7,989,240	14,341,124	-0-	14,341,124

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT		371,995
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		398,483
5	0500	EMPLOYEE BENEFITS		1,369,199
6	0600	ADMINISTRATIVE & GENERAL	-92,240	2,309,167
7	0700	MAINTENANCE & REPAIRS		447,671
8	0800	OPERATION OF PLANT	-92,164	293,669
9	0900	LAUNDRY & LINEN SERVICE		62,534
10	1000	HOUSEKEEPING		193,213
11	1100	DIETARY	-255,845	303,471
12	1200	CAFETERIA	-77,093	45,072
14	1400	NURSING ADMINISTRATION		362,303
17	1700	MEDICAL RECORDS & LIBRARY		179,118
18	1800	SOCIAL SERVICE		
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		637,739
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM	-2,000	190,341
40	4000	ANESTHESIOLOGY	-38,383	8,344
41	4100	RADIOLOGY-DIAGNOSTIC		680,651
44	4400	LABORATORY	-26,988	593,533
49	4900	RESPIRATORY THERAPY	-32,400	268,136
50	5000	PHYSICAL THERAPY		207,332
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		480,854
56	5600	DRUGS CHARGED TO PATIENTS	-6,284	506,183
59	3020	OP PSYCH	-36,000	343,198
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC		4,933
61	6100	EMERGENCY	-871,134	1,164,196
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310	RURAL HEALTH CLINIC		1,149,918
63.51	6311	RURAL HEALTH CLINIC 2		47,477
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
95		SUBTOTALS	-1,530,531	12,618,730
		NONREIMBURS COST CENTERS		
100	7954	OTHER NONREIMBURSABLE COST CENTERS		
100.01	7951	UNASSIGNED SPACE		
100.02	7952	LEASED CLINICS		112,302
100.03	7953	MARKETING		79,561
101		TOTAL	-1,530,531	12,810,593

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2010
I 14-1321 I FROM 7/ 1/2009 I NOT A CMS WORKSHEET
I I TO 6/30/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	OP PSYCH	3020	ACUPUNCTURE
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
63.51	RURAL HEALTH CLINIC 2	6311	RURAL HEALTH CLINIC #####
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
100	OTHER NONREIMBURSABLE COST CENTERS	7954	OTHER NONREIMBURSABLE COST CENTERS
100.01	UNASSIGNED SPACE	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	LEASED CLINICS	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	MARKETING	7953	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
141321	FROM 7/ 1/2009	WORKSHEET A-6
	TO 6/30/2010	

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	INCREASE SALARY	INCREASE OTHER
	1		2	3	4	5
1	CAFETERIA	A	CAFETERIA	12	65,983	56,182
2	SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		393,033
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17	INTEREST	C	NEW CAP REL COSTS-MVBLE EQUIP	4		21,788
18			ADMINISTRATIVE & GENERAL	6		311,443
36	TOTAL RECLASSIFICATIONS				65,983	782,446

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

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	DECREASE SALARY	DECREASE OTHER	A-7 REF
	1		6	7	8	9	10
1	CAFETERIA	A	DIETARY	11	65,983	56,182	
2	SUPPLIES	B	ADULTS & PEDIATRICS	25		21,645	
3			OPERATING ROOM	37		15,098	
4			ANESTHESIOLOGY	40		5,368	
5			RADIOLOGY-DIAGNOSTIC	41		23,176	
6			LABORATORY	44		256,700	
7			RESPIRATORY THERAPY	49		12,034	
8			PHYSICAL THERAPY	50		1,762	
9			DRUGS CHARGED TO PATIENTS	56		1,336	
10			OP PSYCH	59		3,135	
11			CLINIC	60		30	
12			EMERGENCY	61		35,913	
13			RURAL HEALTH CLINIC	63.50		15,372	
14			RURAL HEALTH CLINIC 2	63.51		368	
15			LEASED CLINICS	100.02		786	
16			MARKETING	100.03		310	
17	INTEREST	C	INTEREST EXPENSE	88		333,231	11
18							
36	TOTAL RECLASSIFICATIONS				65,983	782,446	

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

RECLASS CODE: A
EXPLANATION : CAFETERIA

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	122,165	DIETARY	11	122,165
TOTAL RECLASSIFICATIONS FOR CODE A			122,165			122,165

RECLASS CODE: B
EXPLANATION : SUPPLIES

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	393,033	ADULTS & PEDIATRICS	25	21,645
2.00			0	OPERATING ROOM	37	15,098
3.00			0	ANESTHESIOLOGY	40	5,368
4.00			0	RADIOLOGY-DIAGNOSTIC	41	23,176
5.00			0	LABORATORY	44	256,700
6.00			0	RESPIRATORY THERAPY	49	12,034
7.00			0	PHYSICAL THERAPY	50	1,762
8.00			0	DRUGS CHARGED TO PATIENTS	56	1,336
9.00			0	OP PSYCH	59	3,135
10.00			0	CLINIC	60	30
11.00			0	EMERGENCY	61	35,913
12.00			0	RURAL HEALTH CLINIC	63.50	15,372
13.00			0	RURAL HEALTH CLINIC 2	63.51	368
14.00			0	LEASED CLINICS	100.02	786
15.00			0	MARKETING	100.03	310
TOTAL RECLASSIFICATIONS FOR CODE B			393,033			393,033

RECLASS CODE: C
EXPLANATION : INTEREST

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	21,788	INTEREST EXPENSE	88	333,231
2.00	ADMINISTRATIVE & GENERAL	6	311,443			0
TOTAL RECLASSIFICATIONS FOR CODE C			333,231			333,231

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET A-7 I PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	PURCHASES 2	DONATION 3	TOTAL 4	5	6	7
1	LAND	18,401					18,401	
2	LAND IMPROVEMENTS	103,779					103,779	
3	BUILDINGS & FIXTURE	10,553,632	135,404		135,404		10,689,036	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	4,462,634	360,295		360,295		4,822,929	
7	SUBTOTAL	15,138,446	495,699		495,699		15,634,145	
8	RECONCILING ITEMS							
9	TOTAL	15,138,446	495,699		495,699		15,634,145	

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL IN LIEU OF FORM CMS-2552-96(12/1999)
RECONCILIATION OF CAPITAL COSTS CENTERS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2010
I 14-1321 I FROM 7/ 1/2009 I WORKSHEET A-7
I I TO 6/30/2010 I PARTS III & IV

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		GROSS ASSETS	CAPITLIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	10,811,216		10,811,216	.691513				
4	NEW CAP REL COSTS-MV	4,822,929		4,822,929	.308487				
5	TOTAL	15,634,145		15,634,145	1.000000				

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	371,995						371,995
4	NEW CAP REL COSTS-MV	376,695		21,788				398,483
5	TOTAL	748,690		21,788				770,478

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	371,995						371,995
4	NEW CAP REL COSTS-MV	376,695						376,695
5	TOTAL	748,690						748,690

---

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	11
5	INVESTMENT INCOME-OTHER	B	-5,126	ADMINISTRATIVE & GENERAL	6	
6	TRADE, QUANTITY AND TIME DISCOUNTS	B	-452	ADMINISTRATIVE & GENERAL	6	
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,006,270			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-77,093	CAFETERIA	12	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-6,284	DRUGS CHARGED TO PATIENTS	56	
20	SALE OF MEDICAL RECORDS & ABSTRACTS					
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	DIETARY	B	-275	DIETARY	11	
38	MISCELLANEOUS INCOME	B	-5,202	ADMINISTRATIVE & GENERAL	6	
39	ADVERTISING	B	-2,557	ADMINISTRATIVE & GENERAL	6	
40	LAB REVENUE	B	-635	LABORATORY	44	
41	NON CAH MISCELLANEOUS INCOME	B	-59,674	ADMINISTRATIVE & GENERAL	6	
42	BENTON DIETARY	B	-255,570	DIETARY	11	
43	BENTON UTILITIES	A	-92,164	OPERATION OF PLANT	8	
44	PHYSICIAN	A	-19,229	ADMINISTRATIVE & GENERAL	6	
45						
46						
47						
48						
49	OTHER ADJUSTMENTS (SPECIFY)					
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,530,531			

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	37	OR	2,000	2,000					
2	40	ANESTHESIA	38,383	38,383					
3	44	LAB	26,353	26,353					
4	49	RT	32,400	32,400					
5	59	SENIOR CARE	36,000	36,000					
6	61	ER	1,220,578	871,134	349,444				
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	1,355,714	1,006,270	349,444				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10		COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	37	OR								2,000
2	40	ANESTHESIA								38,383
3	44	LAB								26,353
4	49	RT								32,400
5	59	SENIOR CARE								36,000
6	61	ER								871,134
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
101		TOTAL								1,006,270

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

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	160
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	37
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		1239.00	1369.00		
10	AHSEA (SEE INSTRUCTIONS)		57.85	57.85		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	28.93	28.93	28.93		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	71,676
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	79,197
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	150,873
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	150,873

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	150,873

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

STANDARD TRAVEL ALLOWANCE

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	4,629
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	1,070
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	5,699
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	680
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	6,379

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	

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

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	8,257
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

STANDARD TRAVEL EXPENSE

36	THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)	
37	ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)	
38	SUBTOTAL (SUM OF LINES 36 AND 37)	
39	STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)	
40	THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)	
41	ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)	
42	SUBTOTAL (SUM OF LINES 40 AND 41)	
43	OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)	

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES; COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE

44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)	
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)	
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)	

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	150,873
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	8,257
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	

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

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	159,130
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	145,252
65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	145,252
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	145,252
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL IN LIEU OF FORM CMS-2552-96(7/2009)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/19/2010
I 14-1321 I FROM 7/ 1/2009 I NOT A CMS WORKSHEET
I I TO 6/30/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	1	SQUARE FEET	ENTERED
8	OPERATION OF PLANT	2	SQ FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF SERVICE	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	11	FTES	ENTERED
14	NURSING ADMINISTRATION	13	NRSNG FTES	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	GROSS REV	ENTERED
18	SOCIAL SERVICE	17	TIME SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET B I PART I

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
			0	3	4	5	5a.00	6	7
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	371,995	371,995					
004		NEW CAP REL COSTS-MVBLE E	398,483		398,483				
005		EMPLOYEE BENEFITS	1,369,199	1,316		1,370,515			
006		ADMINISTRATIVE & GENERAL	2,309,167	35,909	7,104	209,943	2,562,123	2,562,123	
007		MAINTENANCE & REPAIRS	447,671	14,105	64,342	47,066	573,184	143,297	716,481
008		OPERATION OF PLANT	293,669	44,088	43		337,800	84,450	136,738
009		LAUNDRY & LINEN SERVICE	62,534	3,876	15		66,425	16,606	12,021
010		HOUSEKEEPING	193,213	1,245		38,155	232,613	58,153	3,860
011		DIETARY	303,471	25,633	6,087	65,681	400,872	100,218	79,499
012		CAFETERIA	45,072			14,346	59,418	14,855	
014		NURSING ADMINISTRATION	362,303	1,754	39	77,935	442,031	110,508	5,441
017		MEDICAL RECORDS & LIBRARY	179,118	5,435	27,062	29,834	241,449	60,362	16,856
018		SOCIAL SERVICE		1,274			1,274	319	3,952
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	637,739	31,038	57,353	134,161	860,291	215,074	96,262
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	190,341	33,284	39,945	31,443	295,013	73,754	103,229
040		ANESTHESIOLOGY	8,344	533	319		9,196	2,299	1,654
041		RADIOLOGY-DIAGNOSTIC	680,651	14,271	53,925	97,273	846,120	211,531	44,262
044		LABORATORY	593,533	7,871	11,089	83,181	695,674	173,919	24,410
049		RESPIRATORY THERAPY	268,136	7,017	6,573	51,116	332,842	83,211	21,763
050		PHYSICAL THERAPY	207,332	6,780	771	2,580	217,463	54,366	21,028
055		MEDICAL SUPPLIES CHARGED	480,854	13,086	1,086	14,508	509,534	127,384	40,586
056		DRUGS CHARGED TO PATIENTS	506,183	5,512		30,302	541,997	135,500	17,095
059		OP PSYCH	343,198	14,597		45,411	403,206	100,802	45,273
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	4,933	533		737	6,203	1,551	1,654
061		EMERGENCY	1,164,196	13,187	439	128,025	1,305,847	326,463	40,898
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	1,149,918	36,389	106	230,073	1,416,486	354,118	
063	51	RURAL HEALTH CLINIC 2	47,477	7,841	11,138	7,677	74,133	18,533	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	12,618,730	326,574	287,436	1,339,447	12,431,194	2,467,273	716,481
		NONREIMBURS COST CENTERS							
100		OTHER NONREIMBURSABLE COS							
100	01	UNASSIGNED SPACE		545			545	136	
100	02	LEASED CLINICS	112,302	44,876	111,047	19,179	287,404	71,851	
100	03	MARKETING	79,561			11,889	91,450	22,863	
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	12,810,593	371,995	398,483	1,370,515	12,810,593	2,562,123	716,481

		COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
			8	9	10	11	12	14	17
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
007		MAINTENANCE & REPAIRS							
008		OPERATION OF PLANT	558,988						
009		LAUNDRY & LINEN SERVICE	9,373	104,425					
010		HOUSEKEEPING	3,010		297,636				
011		DIETARY	61,986			642,575			
012		CAFETERIA			11,236		85,509		
014		NURSING ADMINISTRATION	4,242				787	563,009	
017		MEDICAL RECORDS & LIBRARY	13,142		10,041		5,159		347,009
018		SOCIAL SERVICE	3,081						
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	75,056	38,625	69,090	642,575	28,764	347,735	18,164
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	80,488	20,163	36,816		5,689	68,775	10,447
040		ANESTHESIOLOGY	1,290						451
041		RADIOLOGY-DIAGNOSTIC	34,511	14,842	10,041		7,200		86,866
044		LABORATORY	19,033	7,770	10,041		12,764		91,803
049		RESPIRATORY THERAPY	16,969	108	16,017		7,099		28,834
050		PHYSICAL THERAPY	16,396	3,065	8,606		23		4,767
055		MEDICAL SUPPLIES CHARGED	31,645				2,813		3,471
056		DRUGS CHARGED TO PATIENTS	13,329		7,172		3,366		28,762
059		OP PSYCH	35,300	307			1,940		16,846
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	1,290						498
061		EMERGENCY	31,889	19,436	47,813		9,001	146,499	56,100
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	87,997	109	51,638		125		
063	51	RURAL HEALTH CLINIC 2	18,961				23		
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	558,988	104,425	278,511	642,575	84,753	563,009	347,009
		NONREIMBURS COST CENTERS							
100		OTHER NONREIMBURSABLE COS							
100	01	UNASSIGNED SPACE							
100	02	LEASED CLINICS			19,125				
100	03	MARKETING					756		
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	558,988	104,425	297,636	642,575	85,509	563,009	347,009

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET B I PART I

		COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
			18	25	26	27
		GENERAL SERVICE COST CNTR				
003		NEW CAP REL COSTS-BLDG &				
004		NEW CAP REL COSTS-MVBLE E				
005		EMPLOYEE BENEFITS				
006		ADMINISTRATIVE & GENERAL				
007		MAINTENANCE & REPAIRS				
008		OPERATION OF PLANT				
009		LAUNDRY & LINEN SERVICE				
010		HOUSEKEEPING				
011		DIETARY				
012		CAFETERIA				
014		NURSING ADMINISTRATION				
017		MEDICAL RECORDS & LIBRARY				
018		SOCIAL SERVICE	8,626			
		INPAT ROUTINE SRVC CNTRS				
025		ADULTS & PEDIATRICS	8,626	2,400,262		2,400,262
		ANCILLARY SRVC COST CNTRS				
037		OPERATING ROOM		694,374		694,374
040		ANESTHESIOLOGY		14,890		14,890
041		RADIOLOGY-DIAGNOSTIC		1,255,373		1,255,373
044		LABORATORY		1,035,414		1,035,414
049		RESPIRATORY THERAPY		506,843		506,843
050		PHYSICAL THERAPY		325,714		325,714
055		MEDICAL SUPPLIES CHARGED		715,433		715,433
056		DRUGS CHARGED TO PATIENTS		747,221		747,221
059		OP PSYCH		603,674		603,674
		OUTPAT SERVICE COST CNTRS				
060		CLINIC		11,196		11,196
061		EMERGENCY		1,983,946		1,983,946
062		OBSERVATION BEDS (NON-DIS				
063		OTHER OUTPATIENT SERVICE				
063	50	RURAL HEALTH CLINIC		1,910,473		1,910,473
063	51	RURAL HEALTH CLINIC 2		111,650		111,650
		SPEC PURPOSE COST CENTERS				
095		SUBTOTALS	8,626	12,316,463		12,316,463
		NONREIMBURS COST CENTERS				
100		OTHER NONREIMBURSABLE COS				
100	01	UNASSIGNED SPACE		681		681
100	02	LEASED CLINICS		378,380		378,380
100	03	MARKETING		115,069		115,069
101		CROSS FOOT ADJUSTMENT				
102		NEGATIVE COST CENTER				
103		TOTAL	8,626	12,810,593		12,810,593

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET B I PART III

		COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
			0	3	4	4a	5	6	7
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS		1,316		1,316	1,316		
006		ADMINISTRATIVE & GENERAL		35,909	7,104	43,013	202	43,215	
007		MAINTENANCE & REPAIRS		14,105	64,342	78,447	45	2,417	80,909
008		OPERATION OF PLANT		44,088	43	44,131		1,425	15,443
009		LAUNDRY & LINEN SERVICE		3,876	15	3,891		280	1,358
010		HOUSEKEEPING		1,245		1,245	37	981	436
011		DIETARY		25,633	6,087	31,720	63	1,690	8,977
012		CAFETERIA					14	251	
014		NURSING ADMINISTRATION		1,754	39	1,793	75	1,864	614
017		MEDICAL RECORDS & LIBRARY		5,435	27,062	32,497	29	1,018	1,903
018		SOCIAL SERVICE		1,274		1,274		5	446
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS		31,038	57,353	88,391	129	3,628	10,870
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM		33,284	39,945	73,229	30	1,244	11,657
040		ANESTHESIOLOGY		533	319	852		39	187
041		RADIOLOGY-DIAGNOSTIC		14,271	53,925	68,196	94	3,568	4,998
044		LABORATORY		7,871	11,089	18,960	80	2,934	2,757
049		RESPIRATORY THERAPY		7,017	6,573	13,590	49	1,404	2,458
050		PHYSICAL THERAPY		6,780	771	7,551	2	917	2,375
055		MEDICAL SUPPLIES CHARGED		13,086	1,086	14,172	14	2,149	4,583
056		DRUGS CHARGED TO PATIENTS		5,512		5,512	29	2,286	1,930
059		OP PSYCH		14,597		14,597	44	1,700	5,112
		OUTPAT SERVICE COST CNTRS							
060		CLINIC		533		533	1	26	187
061		EMERGENCY		13,187	439	13,626	123	5,507	4,618
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC		36,389	106	36,495	220	5,969	
063	51	RURAL HEALTH CLINIC 2		7,841	11,138	18,979	7	313	
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS		326,574	287,436	614,010	1,287	41,615	80,909
		NONREIMBURS COST CENTERS							
100		OTHER NONREIMBURSABLE COS							
100	01	UNASSIGNED SPACE		545		545		2	
100	02	LEASED CLINICS		44,876	111,047	155,923	18	1,212	
100	03	MARKETING					11	386	
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL		371,995	398,483	770,478	1,316	43,215	80,909

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET B PART III

		COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
			8	9	10	11	12	14	17
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
007		MAINTENANCE & REPAIRS							
008		OPERATION OF PLANT	60,999						
009		LAUNDRY & LINEN SERVICE	1,023	6,552					
010		HOUSEKEEPING	328		3,027				
011		DIETARY	6,764			49,214			
012		CAFETERIA			114		379		
014		NURSING ADMINISTRATION	463				3	4,812	
017		MEDICAL RECORDS & LIBRARY	1,434		102		23		37,006
018		SOCIAL SERVICE	336						
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	8,190	2,424	703	49,214	128	2,972	1,937
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	8,783	1,265	374		25	588	1,114
040		ANESTHESIOLOGY	141						48
041		RADIOLOGY-DIAGNOSTIC	3,766	931	102		32		9,264
044		LABORATORY	2,077	488	102		57		9,790
049		RESPIRATORY THERAPY	1,852	7	163		31		3,075
050		PHYSICAL THERAPY	1,789	192	88				508
055		MEDICAL SUPPLIES CHARGED	3,453				12		370
056		DRUGS CHARGED TO PATIENTS	1,454		73		15		3,067
059		OP PSYCH	3,852	19			9		1,797
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	141						53
061		EMERGENCY	3,480	1,219	486		40	1,252	5,983
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	9,604	7	525		1		
063	51	RURAL HEALTH CLINIC 2	2,069						
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	60,999	6,552	2,832	49,214	376	4,812	37,006
		NONREIMBURS COST CENTERS							
100		OTHER NONREIMBURSABLE COS							
100	01	UNASSIGNED SPACE							
100	02	LEASED CLINICS			195				
100	03	MARKETING					3		
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	60,999	6,552	3,027	49,214	379	4,812	37,006

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET B I PART III

		COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
			18	25	26	27
		GENERAL SERVICE COST CNTR				
003		NEW CAP REL COSTS-BLDG &				
004		NEW CAP REL COSTS-MVBLE E				
005		EMPLOYEE BENEFITS				
006		ADMINISTRATIVE & GENERAL				
007		MAINTENANCE & REPAIRS				
008		OPERATION OF PLANT				
009		LAUNDRY & LINEN SERVICE				
010		HOUSEKEEPING				
011		DIETARY				
012		CAFETERIA				
014		NURSING ADMINISTRATION				
017		MEDICAL RECORDS & LIBRARY				
018		SOCIAL SERVICE	2,061			
		INPAT ROUTINE SRVC CNTRS				
025		ADULTS & PEDIATRICS	2,061	170,647		170,647
		ANCILLARY SRVC COST CNTRS				
037		OPERATING ROOM		98,309		98,309
040		ANESTHESIOLOGY		1,267		1,267
041		RADIOLOGY-DIAGNOSTIC		90,951		90,951
044		LABORATORY		37,245		37,245
049		RESPIRATORY THERAPY		22,629		22,629
050		PHYSICAL THERAPY		13,422		13,422
055		MEDICAL SUPPLIES CHARGED		24,753		24,753
056		DRUGS CHARGED TO PATIENTS		14,366		14,366
059		OP PSYCH		27,130		27,130
		OUTPAT SERVICE COST CNTRS				
060		CLINIC		941		941
061		EMERGENCY		36,334		36,334
062		OBSERVATION BEDS (NON-DIS				
063		OTHER OUTPATIENT SERVICE				
063	50	RURAL HEALTH CLINIC		52,821		52,821
063	51	RURAL HEALTH CLINIC 2		21,368		21,368
		SPEC PURPOSE COST CENTERS				
095		SUBTOTALS	2,061	612,183		612,183
		NONREIMBURS COST CENTERS				
100		OTHER NONREIMBURSABLE COS				
100	01	UNASSIGNED SPACE		547		547
100	02	LEASED CLINICS		157,348		157,348
100	03	MARKETING		400		400
101		CROSS FOOT ADJUSTMENTS				
102		NEGATIVE COST CENTER				
103		TOTAL	2,061	770,478		770,478

	COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE & (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)
		3	4	5	6a.00	6	7
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	62,767					
004	NEW CAP REL COSTS-MVB		467,962				
005	EMPLOYEE BENEFITS	222		6,303,577			
006	ADMINISTRATIVE & GENE	6,059	8,343	965,614	-2,562,123	10,248,470	
007	MAINTENANCE & REPAIRS	2,380	75,560	216,475		573,184	38,979
008	OPERATION OF PLANT	7,439	50			337,800	7,439
009	LAUNDRY & LINEN SERVI	654	18			66,425	654
010	HOUSEKEEPING	210		175,490		232,613	210
011	DIETARY	4,325	7,148	302,095		400,872	4,325
012	CAFETERIA			65,983		59,418	
014	NURSING ADMINISTRATIO	296	46	358,457		442,031	296
017	MEDICAL RECORDS & LIB	917	31,781	137,217		241,449	917
018	SOCIAL SERVICE	215				1,274	215
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	5,237	67,353	617,063		860,291	5,237
	ANCILLARY SRVC COST C						
037	OPERATING ROOM	5,616	46,910	144,621		295,013	5,616
040	ANESTHESIOLOGY	90	375			9,196	90
041	RADIOLOGY-DIAGNOSTIC	2,408	63,327	447,398		846,120	2,408
044	LABORATORY	1,328	13,023	382,583		695,674	1,328
049	RESPIRATORY THERAPY	1,184	7,719	235,105		332,842	1,184
050	PHYSICAL THERAPY	1,144	905	11,866		217,463	1,144
055	MEDICAL SUPPLIES CHAR	2,208	1,275	66,728		509,534	2,208
056	DRUGS CHARGED TO PATI	930		139,371		541,997	930
059	OP PSYCH	2,463		208,866		403,206	2,463
	OUTPAT SERVICE COST C						
060	CLINIC	90		3,389		6,203	90
061	EMERGENCY	2,225	516	588,839		1,305,847	2,225
062	OBSERVATION BEDS (NON						
063	OTHER OUTPATIENT SERV						
063 50	RURAL HEALTH CLINIC	6,140	125	1,058,212		1,416,486	
063 51	RURAL HEALTH CLINIC 2	1,323	13,080	35,310		74,133	
	SPEC PURPOSE COST CEN						
095	SUBTOTALS	55,103	337,554	6,160,682	-2,562,123	9,869,071	38,979
	NONREIMBURS COST CENT						
100	OTHER NONREIMBURSABLE						
100 01	UNASSIGNED SPACE	92				545	
100 02	LEASED CLINICS	7,572	130,408	88,212		287,404	
100 03	MARKETING			54,683		91,450	
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	371,995	398,483	1,370,515		2,562,123	716,481
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	5.926602	.851529	.217419		.250001	18.381205
105	COST TO BE ALLOCATED (WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107	COST TO BE ALLOCATED (WRKSHT B, PART III			1,316		43,215	80,909
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)			.000209		.004217	2.075707

	COST CENTER DESCRIPTION	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (NRSNG FTES)	MEDICAL RECORDS & LIBRARY (GROSS REV)
		8	9	10	11	12	14	17
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	39,003						
009	LAUNDRY & LINEN SERVI	654	106,349					
010	HOUSEKEEPING	210		2,490				
011	DIETARY	4,325			6,083			
012	CAFETERIA			94		10,973		
014	NURSING ADMINISTRATIO	296				101	5,976	
017	MEDICAL RECORDS & LIB	917		84		662		21,679,582
018	SOCIAL SERVICE	215						
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	5,237	39,338	578	6,083	3,691	3,691	1,134,811
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	5,616	20,534	308		730	730	652,695
040	ANESTHESIOLOGY	90						28,207
041	RADIOLOGY-DIAGNOSTIC	2,408	15,115	84		924		5,427,096
044	LABORATORY	1,328	7,913	84		1,638		5,735,157
049	RESPIRATORY THERAPY	1,184	110	134		911		1,801,442
050	PHYSICAL THERAPY	1,144	3,121	72		3		297,803
055	MEDICAL SUPPLIES CHAR	2,208				361		216,878
056	DRUGS CHARGED TO PATI	930		60		432		1,796,982
059	OP PSYCH	2,463	313			249		1,052,472
	OUTPAT SERVICE COST C							
060	CLINIC	90						31,097
061	EMERGENCY	2,225	19,794	400		1,155	1,555	3,504,942
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063 50	RURAL HEALTH CLINIC	6,140	111	432		16		
063 51	RURAL HEALTH CLINIC 2	1,323				3		
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	39,003	106,349	2,330	6,083	10,876	5,976	21,679,582
	NONREIMBURS COST CENT							
100	OTHER NONREIMBURSABLE							
100 01	UNASSIGNED SPACE							
100 02	LEASED CLINICS			160				
100 03	MARKETING					97		
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	558,988	104,425	297,636	642,575	85,509	563,009	347,009
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	14.331923	.981909	119.532530	105.634555	7.792673	94.211680	.016006
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III	60,999	6,552	3,027	49,214	379	4,812	37,006
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	1.563957	.061608	1.215663	8.090416	.034539	.805221	.001707

	COST CENTER DESCRIPTION	SOCIAL SERVICE (TIME SPENT)
		18
	GENERAL SERVICE COST	
003	NEW CAP REL COSTS-BLD	
004	NEW CAP REL COSTS-MVB	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENE	
007	MAINTENANCE & REPAIRS	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVI	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATIO	
017	MEDICAL RECORDS & LIB	
018	SOCIAL SERVICE	100
	INPAT ROUTINE SRVC CN	
025	ADULTS & PEDIATRICS	100
	ANCILLARY SRVC COST C	
037	OPERATING ROOM	
040	ANESTHESIOLOGY	
041	RADIOLOGY-DIAGNOSTIC	
044	LABORATORY	
049	RESPIRATORY THERAPY	
050	PHYSICAL THERAPY	
055	MEDICAL SUPPLIES CHAR	
056	DRUGS CHARGED TO PATI	
059	OP PSYCH	
	OUTPAT SERVICE COST C	
060	CLINIC	
061	EMERGENCY	
062	OBSERVATION BEDS (NON	
063	OTHER OUTPATIENT SERV	
063 50	RURAL HEALTH CLINIC	
063 51	RURAL HEALTH CLINIC 2	
	SPEC PURPOSE COST CEN	
095	SUBTOTALS	100
	NONREIMBURS COST CENT	
100	OTHER NONREIMBURSABLE	
100 01	UNASSIGNED SPACE	
100 02	LEASED CLINICS	
100 03	MARKETING	
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	COST TO BE ALLOCATED (PER WRKSHT B, PART	8,626
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	86.260000
105	COST TO BE ALLOCATED (PER WRKSHT B, PART	
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)	
107	COST TO BE ALLOCATED (PER WRKSHT B, PART	2,061
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	20.610000

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
		INPAT ROUTINE SRVC CNTRS					
25		ADULTS & PEDIATRICS	2,400,262		2,400,262		
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	694,374		694,374		
40		ANESTHESIOLOGY	14,890		14,890		
41		RADIOLOGY-DIAGNOSTIC	1,255,373		1,255,373		
44		LABORATORY	1,035,414		1,035,414		
49		RESPIRATORY THERAPY	506,843		506,843		
50		PHYSICAL THERAPY	325,714		325,714		
55		MEDICAL SUPPLIES CHARGED	715,433		715,433		
56		DRUGS CHARGED TO PATIENTS	747,221		747,221		
59		OP PSYCH	603,674		603,674		
		OUTPAT SERVICE COST CNTRS					
60		CLINIC	11,196		11,196		
61		EMERGENCY	1,983,946		1,983,946		
62		OBSERVATION BEDS (NON-DIS	309,657		309,657		
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC	1,910,473		1,910,473		
63	51	RURAL HEALTH CLINIC 2	111,650		111,650		
		OTHER REIMBURS COST CNTRS					
101		SUBTOTAL	12,626,120		12,626,120		
102		LESS OBSERVATION BEDS	309,657		309,657		
103		TOTAL	12,316,463		12,316,463		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	1,007,258		1,007,258			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	4,373	648,321	652,694	1.063858	1.063858	
40		ANESTHESIOLOGY						
41		RADIOLOGY-DIAGNOSTIC	228,021	5,199,075	5,427,096	.231316	.231316	
44		LABORATORY	428,701	5,306,456	5,735,157	.180538	.180538	
49		RESPIRATORY THERAPY	289,444	1,262,975	1,552,419	.326486	.326486	
50		PHYSICAL THERAPY	52,914	244,889	297,803	1.093723	1.093723	
55		MEDICAL SUPPLIES CHARGED	206,496	259,405	465,901	1.535590	1.535590	
56		DRUGS CHARGED TO PATIENTS	552,327	1,244,655	1,796,982	.415820	.415820	
59		OP PSYCH		1,052,472	1,052,472	.573577	.573577	
		OUTPAT SERVICE COST CNTRS						
60		CLINIC		31,097	31,097	.360035	.360035	
61		EMERGENCY	36,209	3,468,733	3,504,942	.566042	.566042	
62		OBSERVATION BEDS (NON-DIS		127,553	127,553	2.427673	2.427673	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		1,318,832	1,318,832	1.448610	1.448610	
63	51	RURAL HEALTH CLINIC 2		33,612	33,612	3.321730	3.321730	
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	2,805,743	20,198,075	23,003,818			
102		LESS OBSERVATION BEDS						
103		TOTAL	2,805,743	20,198,075	23,003,818			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
		INPAT ROUTINE SRVC CNTRS					
25		ADULTS & PEDIATRICS	2,400,262		2,400,262		
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	694,374		694,374		
40		ANESTHESIOLOGY	14,890		14,890		
41		RADIOLOGY-DIAGNOSTIC	1,255,373		1,255,373		
44		LABORATORY	1,035,414		1,035,414		
49		RESPIRATORY THERAPY	506,843		506,843		
50		PHYSICAL THERAPY	325,714		325,714		
55		MEDICAL SUPPLIES CHARGED	715,433		715,433		
56		DRUGS CHARGED TO PATIENTS	747,221		747,221		
59		OP PSYCH	603,674		603,674		
		OUTPAT SERVICE COST CNTRS					
60		CLINIC	11,196		11,196		
61		EMERGENCY	1,983,946		1,983,946		
62		OBSERVATION BEDS (NON-DIS	309,657		309,657		
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC	1,910,473		1,910,473		
63	51	RURAL HEALTH CLINIC 2	111,650		111,650		
		OTHER REIMBURS COST CNTRS					
101		SUBTOTAL	12,626,120		12,626,120		
102		LESS OBSERVATION BEDS	309,657		309,657		
103		TOTAL	12,316,463		12,316,463		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	1,007,258		1,007,258			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	4,373	648,321	652,694	1.063858	1.063858	
40		ANESTHESIOLOGY						
41		RADIOLOGY-DIAGNOSTIC	228,021	5,199,075	5,427,096	.231316	.231316	
44		LABORATORY	428,701	5,306,456	5,735,157	.180538	.180538	
49		RESPIRATORY THERAPY	289,444	1,262,975	1,552,419	.326486	.326486	
50		PHYSICAL THERAPY	52,914	244,889	297,803	1.093723	1.093723	
55		MEDICAL SUPPLIES CHARGED	206,496	259,405	465,901	1.535590	1.535590	
56		DRUGS CHARGED TO PATIENTS	552,327	1,244,655	1,796,982	.415820	.415820	
59		OP PSYCH		1,052,472	1,052,472	.573577	.573577	
		OUTPAT SERVICE COST CNTRS						
60		CLINIC		31,097	31,097	.360035	.360035	
61		EMERGENCY	36,209	3,468,733	3,504,942	.566042	.566042	
62		OBSERVATION BEDS (NON-DIS		127,553	127,553	2.427673	2.427673	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		1,318,832	1,318,832	1.448610	1.448610	
63	51	RURAL HEALTH CLINIC 2		33,612	33,612	3.321730	3.321730	
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	2,805,743	20,198,075	23,003,818			
102		LESS OBSERVATION BEDS						
103		TOTAL	2,805,743	20,198,075	23,003,818			

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	694,374	98,309	596,065			694,374
40		ANESTHESIOLOGY	14,890	1,267	13,623			14,890
41		RADIOLOGY-DIAGNOSTIC	1,255,373	90,951	1,164,422			1,255,373
44		LABORATORY	1,035,414	37,245	998,169			1,035,414
49		RESPIRATORY THERAPY	506,843	22,629	484,214			506,843
50		PHYSICAL THERAPY	325,714	13,422	312,292			325,714
55		MEDICAL SUPPLIES CHARGED	715,433	24,753	690,680			715,433
56		DRUGS CHARGED TO PATIENTS	747,221	14,366	732,855			747,221
59		OP PSYCH	603,674	27,130	576,544			603,674
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	11,196	941	10,255			11,196
61		EMERGENCY	1,983,946	36,334	1,947,612			1,983,946
62		OBSERVATION BEDS (NON-DIS	309,657		309,657			309,657
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	1,910,473	52,821	1,857,652			1,910,473
63	51	RURAL HEALTH CLINIC 2	111,650	21,368	90,282			111,650
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	10,225,858	441,536	9,784,322			10,225,858
102		LESS OBSERVATION BEDS	309,657		309,657			309,657
103		TOTAL	9,916,201	441,536	9,474,665			9,916,201

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	652,694	1.063858	1.063858
40		ANESTHESIOLOGY			
41		RADIOLOGY-DIAGNOSTIC	5,427,096	.231316	.231316
44		LABORATORY	5,735,157	.180538	.180538
49		RESPIRATORY THERAPY	1,552,419	.326486	.326486
50		PHYSICAL THERAPY	297,803	1.093723	1.093723
55		MEDICAL SUPPLIES CHARGED	465,901	1.535590	1.535590
56		DRUGS CHARGED TO PATIENTS	1,796,982	.415820	.415820
59		OP PSYCH	1,052,472	.573577	.573577
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	31,097	.360035	.360035
61		EMERGENCY	3,504,942	.566042	.566042
62		OBSERVATION BEDS (NON-DIS	127,553	2.427673	2.427673
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	1,318,832	1.448610	1.448610
63	51	RURAL HEALTH CLINIC 2	33,612	3.321730	3.321730
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	21,996,560		
102		LESS OBSERVATION BEDS	127,553		
103		TOTAL	21,869,007		

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27	CAPITAL COST WKST B PT II & III, COL. 27	OPERATING COST NET OF CAPITAL COST	CAPITAL REDUCTION	OPERATING COST REDUCTION AMOUNT	COST NET OF CAP AND OPER COST REDUCTION
			1	2	3	4	5	6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	694,374	98,309	596,065			694,374
40		ANESTHESIOLOGY	14,890	1,267	13,623			14,890
41		RADIOLOGY-DIAGNOSTIC	1,255,373	90,951	1,164,422			1,255,373
44		LABORATORY	1,035,414	37,245	998,169			1,035,414
49		RESPIRATORY THERAPY	506,843	22,629	484,214			506,843
50		PHYSICAL THERAPY	325,714	13,422	312,292			325,714
55		MEDICAL SUPPLIES CHARGED	715,433	24,753	690,680			715,433
56		DRUGS CHARGED TO PATIENTS	747,221	14,366	732,855			747,221
59		OP PSYCH	603,674	27,130	576,544			603,674
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	11,196	941	10,255			11,196
61		EMERGENCY	1,983,946	36,334	1,947,612			1,983,946
62		OBSERVATION BEDS (NON-DIS	309,657		309,657			309,657
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	1,910,473	52,821	1,857,652			1,910,473
63	51	RURAL HEALTH CLINIC 2	111,650	21,368	90,282			111,650
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	10,225,858	441,536	9,784,322			10,225,858
102		LESS OBSERVATION BEDS	309,657		309,657			309,657
103		TOTAL	9,916,201	441,536	9,474,665			9,916,201

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT & COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	652,694	1.063858	1.063858
40		ANESTHESIOLOGY			
41		RADIOLOGY-DIAGNOSTIC	5,427,096	.231316	.231316
44		LABORATORY	5,735,157	.180538	.180538
49		RESPIRATORY THERAPY	1,552,419	.326486	.326486
50		PHYSICAL THERAPY	297,803	1.093723	1.093723
55		MEDICAL SUPPLIES CHARGED	465,901	1.535590	1.535590
56		DRUGS CHARGED TO PATIENTS	1,796,982	.415820	.415820
59		OP PSYCH	1,052,472	.573577	.573577
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	31,097	.360035	.360035
61		EMERGENCY	3,504,942	.566042	.566042
62		OBSERVATION BEDS (NON-DIS	127,553	2.427673	2.427673
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	1,318,832	1.448610	1.448610
63	51	RURAL HEALTH CLINIC 2	33,612	3.321730	3.321730
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	21,996,560		
102		LESS OBSERVATION BEDS	127,553		
103		TOTAL	21,869,007		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART III

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	348,843	370,613			
40		ANESTHESIOLOGY	8,150	17,482			
41		RADIOLOGY-DIAGNOSTIC	663,954	2,751,174			
44		LABORATORY	466,371	2,435,102			
49		RESPIRATORY THERAPY	260,746	771,820			
50		PHYSICAL THERAPY	185,853	126,080			
55		MEDICAL SUPPLIES CHARGED	416,927	249,895			
56		DRUGS CHARGED TO PATIENTS	328,539	759,385			
59		OP PSYCH		748,376			
		OUTPAT SERVICE COST CNTRS					
60		CLINIC	285,980	494,357			
61		EMERGENCY	905,105	1,783,848			
62		OBSERVATION BEDS (NON-DIS	242,685	94,941			
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC	704,119	443,478			
63	51	RURAL HEALTH CLINIC 2					
		OTHER REIMBURS COST CNTRS					
101		TOTAL	4,817,272	11,046,551			

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET C I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT-PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT-PATIENT COSTS 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	348,843	6,000	354,843	370,613			
40	ANESTHESIOLOGY	8,150	22,819	30,969	17,482			
41	RADIOLOGY-DIAGNOSTIC	663,954		663,954	2,751,174			
44	LABORATORY	466,371	11,721	478,092	2,435,102			
49	RESPIRATORY THERAPY	260,746	22,050	282,796	771,820			
50	PHYSICAL THERAPY	185,853		185,853	126,080			
55	MEDICAL SUPPLIES CHARGED	416,927		416,927	249,895			
56	DRUGS CHARGED TO PATIENTS	328,539		328,539	759,385			
59	OP PSYCH				748,376			
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	285,980		285,980	494,357			
61	EMERGENCY	905,105	428,442	1,333,547	1,783,848			
62	OBSERVATION BEDS (NON-DIS	242,685		242,685	94,941			
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
63 51	RURAL HEALTH CLINIC 2							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	4,113,153	491,032	4,604,185	10,603,073			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1321 I

TITLE XVIII, PART B HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
	Cost Center Description	1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1.063858		1.063858		
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	.231316		.231316		
44	LABORATORY	.180538		.180538		
49	RESPIRATORY THERAPY	.326486		.326486		
50	PHYSICAL THERAPY	1.093723		1.093723		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.535590		1.535590		
56	DRUGS CHARGED TO PATIENTS	.415820		.415820		
59	OP PSYCH	.573577		.573577		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	.360035		.360035		
61	EMERGENCY	.566042		.566042		
62	OBSERVATION BEDS (NON-DISTINCT PART)	2.427673		2.427673		
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
63 51	RURAL HEALTH CLINIC 2					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 6/30/2010	PART V
14-1321		

TITLE XVIII, PART B HOSPITAL

		Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic
	Cost Center Description	4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		458,005			
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC		1,888,649			
44	LABORATORY		2,173,249			
49	RESPIRATORY THERAPY		570,454			
50	PHYSICAL THERAPY		97,260			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		191,504			
56	DRUGS CHARGED TO PATIENTS		720,581			
59	OP PSYCH		938,358			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY		1,117,569			
62	OBSERVATION BEDS (NON-DISTINCT PART)		86,296			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
63 51	RURAL HEALTH CLINIC 2					
101	SUBTOTAL		8,241,925			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		8,241,925			

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1321 I I

TITLE XVIII, PART B HOSPITAL

		All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
	Cost Center Description	9	10	11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	487,252		
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	436,875		
44	LABORATORY	392,354		
49	RESPIRATORY THERAPY	186,245		
50	PHYSICAL THERAPY	106,375		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	294,072		
56	DRUGS CHARGED TO PATIENTS	299,632		
59	OP PSYCH	538,221		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	632,591		
62	OBSERVATION BEDS (NON-DISTINCT PART)	209,498		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
63 51	RURAL HEALTH CLINIC 2			
101	SUBTOTAL	3,583,115		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104	NET CHARGES	3,583,115		

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

I PROVIDER NO:	I PERIOD:	I	PREPARED 11/19/2010
I 14-1321	I FROM 7/ 1/2009	I	WORKSHEET D
I COMPONENT NO:	I TO 6/30/2010	I	PART VI
I 14-1321	I	I	

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.415820
2	PROGRAM VACCINE CHARGES	
3	PROGRAM COSTS	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET D
COMPONENT NO:	TO 6/30/2010	PART V
14-1321		

TITLE XIX - O/P HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All Other (1)
	Cost Center Description	1	2	3	4	5
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1.063858				44,939
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	.231316				1,406,204
44	LABORATORY	.180538				1,162,186
49	RESPIRATORY THERAPY	.326486				207,116
50	PHYSICAL THERAPY	1.093723				54,247
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.535590				22,867
56	DRUGS CHARGED TO PATIENTS	.415820				186,844
59	OP PSYCH	.573577				
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	.360035				7,210
61	EMERGENCY	.566042				1,202,571
62	OBSERVATION BEDS (NON-DISTINCT PART)	2.427673				17,377
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC	1.448610				
63 51	RURAL HEALTH CLINIC 2	3.321730				
101	SUBTOTAL					4,311,561
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					4,311,561

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1321 I

TITLE XIX - O/P HOSPITAL

	Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
		5.01	5.02	5.03	6	7
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
59	OP PSYCH					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
63 51	RURAL HEALTH CLINIC 2					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1321 I

TITLE XIX - O/P HOSPITAL

	Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
		8	9	9.01	9.02	9.03
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		47,809			
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC		325,277			
44	LABORATORY		209,819			
49	RESPIRATORY THERAPY		67,620			
50	PHYSICAL THERAPY		59,331			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		35,114			
56	DRUGS CHARGED TO PATIENTS		77,693			
59	OP PSYCH					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC		2,596			
61	EMERGENCY		680,706			
62	OBSERVATION BEDS (NON-DISTINCT PART)		42,186			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
63 51	RURAL HEALTH CLINIC 2					
101	SUBTOTAL		1,548,151			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		1,548,151			

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

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART I
14-1321		

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	1,403
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,232
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,232
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	86
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	85
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	844
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	86
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	85
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V DR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THRDUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,400,262
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THRDUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED CDST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	292,549
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,107,713
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,007,258
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,007,258
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.092525
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	817.58
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,107,713

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,710.81
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,443,924
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,443,924

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
						1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					608,076
49	TOTAL PROGRAM INPATIENT COSTS					2,052,000

	PASS THROUGH COST ADJUSTMENTS	
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	
52	TOTAL PROGRAM EXCLUDABLE COST	
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	
	TARGET AMOUNT AND LIMIT COMPUTATION	
54	PROGRAM DISCHARGES	
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	
	PROGRAM INPATIENT ROUTINE SWING BED COST	
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	147,130
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	145,419
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	292,549
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO:	I PERIOD:	I	PREPARED 11/19/2010
I 14-1321	I FROM 7/ 1/2009	I	WORKSHEET D-1
I COMPONENT NO:	I TO 6/30/2010	I	PART III
I 14-1321	I	I	

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	181
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,710.81
85	OBSERVATION BED COST	309,657

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I COMPONENT NO: 14-1321 I PREPARED 11/19/2010 I WORKSHEET D-4

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.		COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS		707,176	
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	1.063858		
40		ANESTHESIOLOGY			
41		RADIOLOGY-DIAGNOSTIC	.231316	172,620	39,930
44		LABORATORY	.180538	331,390	59,828
49		RESPIRATORY THERAPY	.326486	245,483	80,147
50		PHYSICAL THERAPY	1.093723	32,757	35,827
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	1.535590	147,047	225,804
56		DRUGS CHARGED TO PATIENTS	.415820	400,511	166,540
59		OP PSYCH	.573577		
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	.360035		
61		EMERGENCY	.566042		
62		OBSERVATION BEDS (NON-DISTINCT PART)	2.427673		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
63	51	RURAL HEALTH CLINIC 2			
		OTHER REIMBURS COST CNTRS			
101		TOTAL		1,329,808	608,076
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		1,329,808	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET D-4

I COMPONENT NO: 14-Z321 I I

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	1.063858		
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.231316	14,710	3,403
44	LABORATORY	.180538	29,451	5,317
49	RESPIRATORY THERAPY	.326486	25,402	8,293
50	PHYSICAL THERAPY	1.093723	19,730	21,579
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.535590	27,960	42,935
56	DRUGS CHARGED TO PATIENTS	.415820	73,379	30,512
59	OP PSYCH	.573577		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.360035		
61	EMERGENCY	.566042		
62	OBSERVATION BEDS (NON-DISTINCT PART)	2.427673		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
63 51	RURAL HEALTH CLINIC 2			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		190,632	112,039
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		190,632	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET D-4

I COMPONENT NO: 14-1321 I

TITLE XIX HOSPITAL OTHER

WKST A LINE NO.		COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS		75,100	
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	1.063858		
40		ANESTHESIOLOGY			
41		RADIOLOGY-DIAGNOSTIC	.231316	26,238	6,069
44		LABORATORY	.180538	49,836	8,997
49		RESPIRATORY THERAPY	.326486	17,035	5,562
50		PHYSICAL THERAPY	1.093723	156	171
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	1.535590	722	1,109
56		DRUGS CHARGED TO PATIENTS	.415820	51,738	21,514
59		OP PSYCH	.573577		
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	.360035		
61		EMERGENCY	.566042	22,188	12,559
62		OBSERVATION BEDS (NON-DISTINCT PART)	2.427673		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC	1.448610		
63	51	RURAL HEALTH CLINIC 2	3.321730		
		OTHER REIMBURS COST CNTRS			
101		TOTAL		167,913	55,981
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		167,913	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET E
COMPONENT NO:	TO 6/30/2010	PART B
14-1321		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,583,115
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	3,583,115
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	3,618,946
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	42,954
18.01	CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	1,212,186
19	SUBTOTAL (SEE INSTRUCTIONS)	2,363,806
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	2,363,806
24	PRIMARY PAYER PAYMENTS	506
25	SUBTOTAL	2,363,300
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	457,185
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	457,185
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	432,709
28	SUBTOTAL	2,820,485
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER AOJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	2,820,485
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,899,697
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-79,212
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,771,270		2,388,115
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			20,224		283,766
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01	10/ 2/2009	2,923	10/ 2/2009	10,838
	ADJUSTMENTS TO PROVIDER	.02	2/ 5/2010	70,532	2/ 5/2010	216,978
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		73,455		227,816
4	TOTAL INTERIM PAYMENTS			1,864,949		2,899,697
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01		45,722		
		SETTLEMENT TO PROGRAM .02				79,212
7	TOTAL MEDICARE PROGRAM LIABILITY			1,910,671		2,820,485

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL

IN LIEU OF FORM CMS-2552-96 (11/1998)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WDRKSHEET E-1
COMPONENT NO:	TO 6/30/2010	
14-Z321		

TITLE XVIII SWING BED SNF

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			359,632		
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01	2/ 5/2010	27,808		
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		27,808		NONE
4	TOTAL INTERIM PAYMENTS			387,440		
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMDUNT (BALANCE DUE) BASED DN COST REPORT (1)	SETTLEMENT TO PRDVIDER .01		20,643		
		SETTLEMENT TO PROGRAM .02				
7	TOTAL MEDICARE PROGRAM LIABILITY			408,083		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

---

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

IN LIEU OF FORM CMS-2552-96-E-2 (05/2004)

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	
COMPONENT NO:	TO 6/30/2010	WORKSHEET E-2
14-Z321		

TITLE XVIII SWING BED SNF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	295,474	
2	INPATIENT RDUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIDNS)	113,159	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	171	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	408,633	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	408,633	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	408,633	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	550	
14	80% OF PART B COSTS		
15	SUBTOTAL	408,083	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	408,083	
19	SEQUESTRATIDN ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	387,440	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	20,643	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTIDN 115.2.		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT

HOSPITAL

1	INPATIENT SERVICES	2,052,000
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,052,000
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,072,520
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	2,072,520
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	185,212
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,887,308
23	COINSURANCE	267
24	SUBTOTAL	1,887,041
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	23,630
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	23,630
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	21,538
26	SUBTOTAL	1,910,671
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMDUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	1,910,671
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	1,864,949
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	45,722
34	PROTESTED AMOUNTS (NDNALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET | PROVIDER NO: 14-1321 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/19/2010 | WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	262,825			
2	TEMPORARY INVESTMENTS	221,441			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	4,154,029			
5	OTHER RECEIVABLES	1,323,134			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,486,864			
7	INVENTORY	177,124			
8	PREPAID EXPENSES	75,075			
9	OTHER CURRENT ASSETS	414,981			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	4,141,745			
	FIXED ASSETS				
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	15,634,145			
14.01	LESS ACCUMULATED DEPRECIATION	-13,183,745			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	2,450,400			
	OTHER ASSETS				
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	14,014			
26	TOTAL OTHER ASSETS	14,014			
27	TOTAL ASSETS	6,606,159			

BALANCE SHEET | PROVIDER NO: 14-1321 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/19/2010 | WORKSHEET G

	LIABILITIES AND FUND BALANCE	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	1,413,391			
29	SALARIES, WAGES & FEES PAYABLE	756,973			
30	PAYROLL TAXES PAYABLE				
31	NOTES AND LOANS PAYABLE (SHORT TERM)	660,405			
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES	864,523			
36	TOTAL CURRENT LIABILITIES	3,695,292			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE				
38	NOTES PAYABLE	3,979,503			
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES	3,979,503			
43	TOTAL LIABILITIES	7,674,795			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	-1,068,636			
45	SPECIFIC PURPOSE FUND				
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49	PLANT FUND BALANCE-INVESTED IN PLANT				
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51	TOTAL FUND BALANCES	-1,068,636			
52	TOTAL LIABILITIES AND FUND BALANCES	6,606,159			

STATEMENT OF CHANGES IN FUND BALANCES

I	PROVIDER NO:	I PERIOD:	I	PREPARED 11/19/2010
I	14-1321	I FROM 7/ 1/2009	I	WORKSHEET G-1
I		I TO 6/30/2010	I	

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		137,877		
2	NET INCOME (LOSS)		-1,206,516		
3	TOTAL		-1,068,639		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM	3			
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS		3		
11	SUBTOTAL		-1,068,636		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		-1,068,636		

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	FUND BALANCE AT BEGINNING OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL				
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET G-2 I PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	1,007,258		1,007,258
4	00	SWING BED - SNF			
5	00	SWING BED - NF			
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	1,007,258		1,007,258
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	1,007,258		1,007,258
17	00	ANCILLARY SERVICES	1,798,484	18,873,838	20,672,322
18	00	OUTPATIENT SERVICES			
18	50	RURAL HEALTH CLINIC		1,318,832	1,318,832
18	51	RURAL HEALTH CLINIC 2		33,612	33,612
24	00	PRO FEES	7,919	1,215,114	1,223,033
25	00	TOTAL PATIENT REVENUES	2,813,661	21,441,396	24,255,057

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		14,341,124
		ADD (SPECIFY)		
27	00	BAD DEBT		
28	00			
29	00			
30	00			
31	00			
32	00			
33	00	TOTAL ADDITIONS		
		DEDUCT (SPECIFY)		
34	00	DEDUCT (SPECIFY)		
35	00			
36	00			
37	00			
38	00			
39	00	TOTAL DEDUCTIONS		
40	00	TOTAL OPERATING EXPENSES		14,341,124

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: 14-1321 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/19/2010 I WORKSHEET G-3 I

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	24,255,057
2	LESS: ALLOWANCES AND DISCOUNTS ON	12,471,820
3	NET PATIENT REVENUES	11,783,237
4	LESS: TOTAL OPERATING EXPENSES	14,341,124
5	NET INCOME FROM SERVICE TO PATIENT	-2,557,887
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS,FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER (SPECIFY)	566,976
24.01		784,395
25	TOTAL OTHER INCOME	1,351,371
26	TOTAL	-1,206,516
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	-1,206,516

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 6/30/2010	
14-3469		

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	436,838		436,838	
2	PHYSICIAN ASSISTANT	88,342		88,342	
3	NURSE PRACTITIONER	181,019		181,019	
4	VISITING NURSE				
5	OTHER NURSE	222,226		222,226	
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS				
10	SUBTOTAL (SUM OF LINES 1-9)	928,425		928,425	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT				
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)				
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES				
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS				
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)				
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	928,425		928,425	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS	129,787	107,078	236,865	-15,372
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	129,787	107,078	236,865	-15,372
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,058,212	107,078	1,165,290	-15,372

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 6/30/2010	
14-3469		

RHC 1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	436,838		436,838
2	PHYSICIAN ASSISTANT	88,342		88,342
3	NURSE PRACTITIONER	181,019		181,019
4	VISITING NURSE			
5	OTHER NURSE	222,226		222,226
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	928,425		928,425
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES			
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)			
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	928,425		928,425
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	221,493		221,493
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	221,493		221,493
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,149,918		1,149,918

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 6/30/2010	
14-8510		

RHC 2

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN				
2	PHYSICIAN ASSISTANT				
3	NURSE PRACTITIONER	23,463		23,463	
4	VISITING NURSE				
5	OTHER NURSE	7,028		7,028	
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS				
10	SUBTOTAL (SUM OF LINES 1-9)	30,491		30,491	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT				
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)				
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES				
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS				
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)				
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	30,491		30,491	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS	4,819	12,535	17,354	-368
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	4,819	12,535	17,354	-368
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	35,310	12,535	47,845	-368

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 6/30/2010	
14-8510		

RHC 2

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN			
2	PHYSICIAN ASSISTANT			
3	NURSE PRACTITIONER	23,463		23,463
4	VISITING NURSE			
5	OTHER NURSE	7,028		7,028
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	30,491		30,491
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES			
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)			
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	30,491		30,491
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	16,986		16,986
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	16,986		16,986
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	47,477		47,477

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-2
COMPONENT NO:	TO 6/30/2010	
14-3469		

RHC 1

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	1.55	4,349	4,200	6,510
2	PHYSICIAN ASSISTANTS	1.03	2,656	2,100	2,163
3	NURSE PRACTITIONERS	1.74	4,217	2,100	3,654
4	SUBTOTAL (SUM OF LINES 1-3)	4.32	11,222		12,327
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4.32	11,222		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	928,425			
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	928,425			
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000			
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	221,493			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	760,555			
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	982,048			
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	982,048			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	982,048			
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,910,473			

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO:	I PERIOD:	I	PREPARED 11/19/2010
I 14-1321	I FROM 7/ 1/2009	I	WORKSHEET M-2
I COMPONENT NO:	I TO 6/30/2010	I	
I 14-3469	I	I	

RHC 1

VISITS AND PRODUCTIVITY

		GREATER OF COL. 2 OR COL. 4
		5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	12,327
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	12,327
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

(1) THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-2
COMPONENT NO:	TO 6/30/2010	
14-8510		

RHC 2

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS			4,200	
2	PHYSICIAN ASSISTANTS			2,100	
3	NURSE PRACTITIONERS	.03	181	2,100	63
4	SUBTOTAL (SUM OF LINES 1-3)	.03	181		63
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	.03	181		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	30,491			
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	30,491			
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000			
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	16,986			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	64,173			
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	81,159			
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	81,159			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	81,159			
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	111,650			

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-2
COMPONENT NO:	TO 6/30/2010	
14-8510		

RHC 2

VISITS AND PRODUCTIVITY

		GREATER OF COL. 2 OR COL. 4
		5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	181
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	181
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

(1) THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

	PROVIDER NO:	PERIOD:		PREPARED 11/19/2010
	14-1321	FROM 7/ 1/2009		WORKSHEET M-3
	COMPONENT NO:	TO 6/30/2010		
	14-3469			

TITLE XVIII RHC 1

	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	1,910,473
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,910,473
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	12,327
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	12,327
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	154.98

		CALCULATION OF LIMIT (1)	
		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	154.98	154.98
	CALCULATION DF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		2,905
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		450,217
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		450,217
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		36,661
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		413,556
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		330,845
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21	TDTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		330,845
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		330,845
25	INTERIM PAYMENTS		316,906
25.01	TENTATIVE SETTLEMENT (FDR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		13,939
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-3
COMPONENT NO:	TO 6/30/2010	
14-8510		

TITLE XVIII RHC 2

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES UCATION PASS THROUGH COST.

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	111,650
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	111,650
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	181
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	181
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	616.85

CALCULATION OF LIMIT (1)

		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	76.84	77.76
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	616.85	616.85
	CALCULATION DF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECDRDS)		27
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		16,655
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TDTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, CDLUMNS 1, 2 AND 3)*		16,655
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		16,655
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		13,324
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		13,324
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		13,324
25	INTERIM PAYMENTS		2,700
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		10,624
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL

IN LIEU OF FORM CMS-2552-96 M-5 (11/1998)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES
[X] RHC [ ] FQHC

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-5
COMPONENT NO:	TO 6/30/2010	
14-3469		

RHC 1

	DESCRIPTION		PART B MM/DD/YYYY 1	AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			326,443
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	ADJUSTMENTS TO PROVIDER	.01		
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50	2/ 5/2010	9,537
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		-9,537
4	TOTAL INTERIM PAYMENTS			316,906
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02		13,939
7	TOTAL MEDICARE PROGRAM LIABILITY			330,845

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

IN LIEU OF FORM CMS-2552-96 M-5 (11/1998)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

[X] RHC [ ] FQHC

PROVIDER NO:	PERIOD:	PREPARED 11/19/2010
14-1321	FROM 7/ 1/2009	WORKSHEET M-5
COMPONENT NO:	TO 6/30/2010	
14-8510		

RHC 2

	DESCRIPTION			PART B MM/DD/YYYY 1	AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				2,700
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.				NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
		ADJUSTMENTS TO PROVIDER	.01		
		ADJUSTMENTS TO PROVIDER	.02		
		ADJUSTMENTS TO PROVIDER	.03		
		ADJUSTMENTS TO PROVIDER	.04		
		ADJUSTMENTS TO PROVIDER	.05		
		ADJUSTMENTS TO PROGRAM	.50		
		ADJUSTMENTS TO PROGRAM	.51		
		ADJUSTMENTS TO PROGRAM	.52		
		ADJUSTMENTS TO PROGRAM	.53		
		ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL		.99		NONE
4	TOTAL INTERIM PAYMENTS				2,700
	TO BE COMPLETED BY INTERMEDIARY				
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
		TENTATIVE TO PROVIDER	.01		
		TENTATIVE TO PROVIDER	.02		
		TENTATIVE TO PROVIDER	.03		
		TENTATIVE TO PROGRAM	.50		
		TENTATIVE TO PROGRAM	.51		
		TENTATIVE TO PROGRAM	.52		
	SUBTOTAL		.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01		10,624
		SETTLEMENT TO PROGRAM	.02		
7	TOTAL MEDICARE PROGRAM LIABILITY				13,324

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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