This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141324	Period: From 04/01/2012 To 03/31/2013	Worksheet S Parts I-III Date/Time Prepared: 8/27/2013 2:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/27/2013 Time: 2:26 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FERRELL HOSPITAL (141324) for the cost reporting period beginning 04/01/2012 and ending 03/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-52,962	261,348	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-23,659	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		129,452		0	10.00
200.00	Total	0	-76,621	390,800	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/27/2013 2:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1201 PINE STREET	PO Box:			1.00
2.00	City: EL DORADO	State: IL	Zip Code: 62930	County: SALINE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FERRELL HOSPITAL	141324	14999	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FERRELL SWINGBED SNF	14Z324	14999		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	ELDORADO	148507	14999		04/01/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II									15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2012	03/31/2013	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 8/27/2013 2:25 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N	N	39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I Date/Time Prepared: 8/27/2013 2:25 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/27/2013 2:25 pm

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part I | Date/Time Prepared: 8/27/2013 2:25 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	37,820	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part II | Date/Time Prepared: 8/27/2013 2:25 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	06/25/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 8/27/2013 2:25 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314)-231-5544	STLHEALTHCARE@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-2 Part II Date/Time Prepared: 8/27/2013 2:25 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	06/25/2013			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR MANAGING CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-3 Part I Date/Time Prepared: 8/27/2013 2:25 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	65,664.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	65,664.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	65,664.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 8/27/2013 2:25 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,890	290	2,736			1.00
2.00	HMO	99	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	227	0	229			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	23			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,117	290	2,988			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,117	290	2,988	0.00	132.24	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,847	0	17,479	0.00	18.02	26.00
26.01	RURAL HEALTH CLINIC II	0	0	0	0.00	0.00	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	150.26	27.00
28.00	Observation Bed Days		0	479			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-3 Part I | Date/Time Prepared: 8/27/2013 2:25 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	560	119	889	1.00
2.00	HMO			27			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	560	119	889	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141324 Component CCN: 148507 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-8 | Date/Time Prepared: 8/27/2013 2:25 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1201 PINE STREET	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	EL DORADO	IL	62930	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	16:00	07:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y	2	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	EL DORADO	148507	14.00
14.01		FERREL HOSPITAL CLINIC	148506	14.01

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

			County				
			4.00				
2.00	City, State, Zip Code, County		SALINE				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:00	07:00	16:00	08:00	16:30	11.00

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

Provider CCN: 141324
Component CCN: 148507

Period:
From 04/01/2012
To 03/31/2013

Worksheet S-8

Date/Time Prepared:
8/27/2013 2:25 pm

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	11:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet S-10 | Date/Time Prepared: 8/27/2013 2:25 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.444471	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,461,235	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,742,087	6.00
7.00	Medicaid cost (line 1 times line 6)	2,996,662	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,535,427	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,535,427	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	765,704	85,261	850,965	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	340,333	37,896	378,229	21.00
22.00	Partial payment by patients approved for charity care	3,283	3,134	6,417	22.00
23.00	Cost of charity care (line 21 minus line 22)	337,050	34,762	371,812	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,715,528	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	690,850	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,024,678	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	455,440	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	827,252	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,362,679	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		563,801	563,801	-71,568	492,233	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	442,601	442,601	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	50,860	2,611,640	2,662,500	0	2,662,500	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	902,645	1,639,502	2,542,147	-19,927	2,522,220	5.00
6.00	00600	MAINTENANCE & REPAIRS	167,467	98,359	265,826	0	265,826	6.00
7.00	00700	OPERATION OF PLANT	0	176,397	176,397	-6,978	169,419	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,997	9,445	52,442	0	52,442	8.00
9.00	00900	HOUSEKEEPING	163,760	26,840	190,600	0	190,600	9.00
10.00	01000	DIETARY	173,064	145,544	318,608	-161,675	156,933	10.00
11.00	01100	CAFETERIA	0	0	0	161,675	161,675	11.00
13.00	01300	NURSING ADMINISTRATION	137,241	5,355	142,596	0	142,596	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	202,241	27,017	229,258	0	229,258	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	72,688	160,678	233,366	0	233,366	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,119,161	33,651	1,152,812	-44,392	1,108,420	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	187,876	85,166	273,042	0	273,042	50.00
53.00	05300	ANESTHESIOLOGY	0	5,608	5,608	0	5,608	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,977	648,981	1,013,958	0	1,013,958	54.00
60.00	06000	LABORATORY	384,100	541,355	925,455	44,392	969,847	60.00
65.00	06500	RESPIRATORY THERAPY	316,258	76,202	392,460	-13,570	378,890	65.00
66.00	06600	PHYSICAL THERAPY	135,526	209,442	344,968	2,412	347,380	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,303	150,283	246,586	13,570	260,156	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	179,349	689,674	869,023	0	869,023	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,235,150	114,182	1,349,332	85,193	1,434,525	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	344,571	126,432	471,003	-665	470,338	90.00
91.00	09100	EMERGENCY	488,012	766,101	1,254,113	-45,775	1,208,338	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		228,511	228,511	-228,511	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,764,246	9,140,166	15,904,412	156,782	16,061,194	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	508,833	115,518	624,351	-56,265	568,086	192.00
192.01	19201	MARKETING	85,393	118,944	204,337	-100,517	103,820	192.01
200.00		TOTAL (SUM OF LINES 118-199)	7,358,472	9,374,628	16,733,100	0	16,733,100	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-9,925	482,308		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	442,601		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	0	2,662,500		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-468,433	2,053,787		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	265,826		6.00
7.00	00700	OPERATION OF PLANT	0	169,419		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	52,442		8.00
9.00	00900	HOUSEKEEPING	0	190,600		9.00
10.00	01000	DIETARY	0	156,933		10.00
11.00	01100	CAFETERIA	-27,496	134,179		11.00
13.00	01300	NURSING ADMINISTRATION	0	142,596		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,877	218,381		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	233,366		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,108,420		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	273,042		50.00
53.00	05300	ANESTHESIOLOGY	0	5,608		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,624	1,012,334		54.00
60.00	06000	LABORATORY	0	969,847		60.00
65.00	06500	RESPIRATORY THERAPY	0	378,890		65.00
66.00	06600	PHYSICAL THERAPY	-2,438	344,942		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	260,156		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-111,076	757,947		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-17,640	1,416,885		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	0	470,338		90.00
91.00	09100	EMERGENCY	-370,997	837,341		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,020,506	15,040,688		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	568,086		192.00
192.01	19201	MARKETING	0	103,820		192.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,020,506	15,712,594		200.00

RECLASSIFICATIONS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-6 | Date/Time Prepared: 8/27/2013 2:25 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COST					
1.00	CAFETERIA	11.00	87,820	73,855		1.00
	TOTALS		87,820	73,855		
	B - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	228,511		1.00
	TOTALS		0	228,511		
	C - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	20,398		1.00
	TOTALS		0	20,398		
	D - TO RECLASS PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	122,124		1.00
	TOTALS		0	122,124		
	E - TO RECLASS MARKET. TEL AND ADV COST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	100,517		1.00
	TOTALS		0	100,517		
	G - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	665		1.00
	TOTALS		0	665		
	H - TO RECLASS ER SAL TO RHC I AND II					
1.00	RURAL HEALTH CLINIC	88.00	45,775	0		1.00
	TOTALS		45,775	0		
	J - TO RECLASS OXYGEN COST TO MSCTP					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,570		1.00
	TOTALS		0	13,570		
	K - TO RECLASS SALARIES TO LAB FOR TRANS					
1.00	LABORATORY	60.00	44,392	0		1.00
	TOTALS		44,392	0		
	L - TO RECLASS NURSING SAL TO RHC					
1.00	RURAL HEALTH CLINIC	88.00	39,418	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	21,413	0		2.00
	TOTALS		60,831	0		
	N - TO RECLASS EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	431,063		1.00
	TOTALS		0	431,063		
	O - TO RECLASS UTILITIES TO RENTAL SPACE					
1.00	PHYSICAL THERAPY	66.00	0	2,412		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,566		2.00
	TOTALS		0	6,978		
500.00	Grand Total: Increases		238,818	997,681		500.00

RECLASSIFICATIONS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-6 | Date/Time Prepared: 8/27/2013 2:25 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - TO RECLASS CAFETERIA COST					
1.00	DIETARY	10.00	87,820	73,855	0	1.00
	TOTALS		87,820	73,855		
	B - TO RECLASS INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	228,511	11	1.00
	TOTALS		0	228,511		
	C - TO RECLASS PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,398	12	1.00
	TOTALS		0	20,398		
	D - TO RECLASS PROPERTY TAXES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	122,124	13	1.00
	TOTALS		0	122,124		
	E - TO RECLASS MARKET. TEL AND ADV COST					
1.00	MARKETING	192.01	0	100,517	0	1.00
	TOTALS		0	100,517		
	G - TO RECLASS TELEPHONE EXPENSE					
1.00	CLINIC	90.00	0	665	0	1.00
	TOTALS		0	665		
	H - TO RECLASS ER SAL TO RHC I AND II					
1.00	EMERGENCY	91.00	45,775	0	0	1.00
	TOTALS		45,775	0		
	J - TO RECLASS OXYGEN COST TO MSCTP					
1.00	RESPIRATORY THERAPY	65.00	0	13,570	0	1.00
	TOTALS		0	13,570		
	K - TO RECLASS SALARIES TO LAB FOR TRANS					
1.00	ADULTS & PEDIATRICS	30.00	44,392	0	0	1.00
	TOTALS		44,392	0		
	L - TO RECLASS NURSING SAL TO RHC					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	60,831	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		60,831	0		
	N - TO RECLASS EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	431,063	9	1.00
	TOTALS		0	431,063		
	O - TO RECLASS UTILITIES TO RENTAL SPACE					
1.00	OPERATION OF PLANT	7.00	0	6,978	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	6,978		
500.00	Grand Total: Decreases		238,818	997,681		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-7 Part I | Date/Time Prepared: 8/27/2013 2:25 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	159,712	0	0	0	0	1.00
2.00	Land Improvements	44,285	0	0	0	0	2.00
3.00	Buildings and Fixtures	2,067,190	801,077	0	801,077	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	632,541	0	0	0	0	5.00
6.00	Movable Equipment	2,188,096	30,531	0	30,531	0	6.00
7.00	HIT designated Assets	555,208	594,138	0	594,138	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,647,032	1,425,746	0	1,425,746	0	8.00
9.00	Reconciling Items	-691,699	-668,567	0	-668,567	-1,358,392	9.00
10.00	Total (line 8 minus line 9)	6,338,731	2,094,313	0	2,094,313	1,358,392	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	159,712	0	1.00
2.00	Land Improvements	44,285	0	2.00
3.00	Buildings and Fixtures	2,868,267	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	632,541	0	5.00
6.00	Movable Equipment	2,218,627	0	6.00
7.00	HIT designated Assets	1,149,346	0	7.00
8.00	Subtotal (sum of lines 1-7)	7,072,778	0	8.00
9.00	Reconciling Items	-1,874	0	9.00
10.00	Total (line 8 minus line 9)	7,074,652	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-7 Part II | Date/Time Prepared: 8/27/2013 2:25 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	562,127	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	562,127	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	1,674	563,801		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	1,674	563,801		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-7 Part III | Date/Time Prepared: 8/27/2013 2:25 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,072,264	0	3,072,264	0.434379	8,860	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,000,514	0	4,000,514	0.565621	11,538	2.00
3.00	Total (sum of lines 1-2)	7,072,778	0	7,072,778	1.000000	20,398	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	8,860	131,064	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	11,538	431,063	0	2.00
3.00	Total (sum of lines 1-2)	0	0	20,398	562,127	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	218,586	8,860	122,124	1,674	482,308	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,538	0	0	442,601	2.00
3.00	Total (sum of lines 1-2)	218,586	20,398	122,124	1,674	924,909	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8 | Date/Time Prepared: 8/27/2013 2:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-9,925	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-2,148	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,016	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-370,997			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-23,284	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-18,625	ADMINISTRATIVE & GENERAL	5.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-111,076	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-10,877	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-4,212	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	X-RAY COPIES	B	-26	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
33.01	SILVERY RECOVERY	B	-1,598	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	MISC INCOME - REBATES	B	-423	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PROVIDER TAX	A	-214,009	ADMINISTRATIVE & GENERAL	5.00	0	33.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8 | Date/Time Prepared: 8/27/2013 2:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.04	MISC INCOME -	B	-58,351	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC INCOME - RENTAL PROPERTY	B	-5,217	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	ADVERTISING EXPENSE	A	-98,517	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MISC INCOME - PT FEES	B	-2,438	PHYSICAL THERAPY	66.00	0	33.07
33.08	LOAN FORGIVENESS	A	-17,640	RURAL HEALTH CLINIC	88.00	0	33.08
33.09	ROTARY DUES	A	-853	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PHYSICIAN RECRUITMENT	A	-68,274	ADMINISTRATIVE & GENERAL	5.00	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,020,506				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-2 | Date/Time Prepared: 8/27/2013 2:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	AGGREGATE-EMERGENCY	732,369	370,997	361,372	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			732,369	370,997	361,372		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	AGGREGATE-EMERGENCY	0	0	0	370,997		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	370,997		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/27/2013 2:25 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					45	1.00
2.00	Line 1 multiplied by 15 hours per week					675	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					139	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					58	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	961.00	861.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.82	55.37	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.91	36.91	27.69			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					70,941	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					47,674	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					118,615	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					118,615	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					118,615	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					5,130	24.00
25.00	Assistants (line 4 times column 3, line 11)					1,606	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					6,736	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,152	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					7,888	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/27/2013 2:25 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.82	55.37	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	118,615	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	118,615	63.00
64.00	Total cost of outside supplier services (from your records)	117,742	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	6,736	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,152	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	7,888	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,152	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,152	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/27/2013 2:25 pm

Occupational Therapy | Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						40	1.00
2.00	Line 1 multiplied by 15 hours per week						600	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						106	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						105	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.85	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	421.00	1,176.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.97	52.48	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.99	34.99	26.24				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						29,457	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						61,716	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						91,173	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						91,173	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						91,173	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						3,709	24.00
25.00	Assistants (line 4 times column 3, line 11)						2,755	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						6,464	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						1,234	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						7,698	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141324	Period: From 04/01/2012 To 03/31/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2013 2:25 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.97	52.48	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	91,173	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	91,173	63.00
64.00	Total cost of outside supplier services (from your records)	51,729	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	6,464	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,234	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	7,698	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,234	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,234	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/27/2013 2:25 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					4	1.00
2.00	Line 1 multiplied by 15 hours per week					60	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					46	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	40.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.24	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.62	33.62	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					2,690	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					2,690	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					2,690	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					67.25	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					4,035	22.00
23.00	Total salary equivalency (see instructions)					4,035	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					1,547	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,547	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					269	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,816	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/27/2013 2:25 pm

Speech Pathology — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.24	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	4,035	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00	
60.00	Overtime allowance (from column 5, line 56)	0	60.00	
61.00	Equipment cost (see instructions)	0	61.00	
62.00	Supplies (see instructions)	0	62.00	
63.00	Total allowance (sum of lines 57-62)	4,035	63.00	
64.00	Total cost of outside supplier services (from your records)	3,771	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00	
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	1,547	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	269	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,816	100.02	
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	269	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01	
101.02	Line 34 = sum of lines 27 and 31	269	101.02	
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01	
102.02	Line 35 = sum of lines 31 and 32	0	102.02	

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part I | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	482,308	482,308				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	442,601		442,601			2.00
4.00	00400	EMPLOYEE BENEFITS	2,662,500	0	0	2,662,500		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,053,787	79,201	65,994	336,677	2,535,659	5.00
6.00	00600	MAINTENANCE & REPAIRS	265,826	19,970	16,640	61,016	363,452	6.00
7.00	00700	OPERATION OF PLANT	169,419	16,725	13,936	0	200,080	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,442	15,491	12,908	15,666	96,507	8.00
9.00	00900	HOUSEKEEPING	190,600	8,931	7,442	59,665	266,638	9.00
10.00	01000	DIETARY	156,933	17,932	14,941	31,058	220,864	10.00
11.00	01100	CAFETERIA	134,179	4,077	3,397	31,997	173,650	11.00
13.00	01300	NURSING ADMINISTRATION	142,596	8,543	7,118	50,003	208,260	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218,381	22,023	18,350	73,686	332,440	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	233,366	0	0	26,484	259,850	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,108,420	60,604	50,498	391,588	1,611,110	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	273,042	29,220	24,348	68,452	395,062	50.00
53.00	05300	ANESTHESIOLOGY	5,608	402	335	0	6,345	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,012,334	33,339	27,780	132,978	1,206,431	54.00
60.00	06000	LABORATORY	969,847	16,448	13,705	156,119	1,156,119	60.00
65.00	06500	RESPIRATORY THERAPY	378,890	25,615	21,343	115,227	541,075	65.00
66.00	06600	PHYSICAL THERAPY	344,942	0	22,672	49,378	416,992	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	260,156	6,809	5,674	35,088	307,727	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	757,947	10,540	8,782	65,345	842,614	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,416,885	68,509	75,134	481,062	2,041,590	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	470,338	20,150	16,790	125,543	632,821	90.00
91.00	09100	EMERGENCY	837,341	17,779	14,814	161,127	1,031,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,040,688	482,308	442,601	2,468,159	14,846,347	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	568,086	0	0	163,228	731,314	192.00
192.01	19201	MARKETING	103,820	0	0	31,113	134,933	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	15,712,594	482,308	442,601	2,662,500	15,712,594	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part I Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,535,659					5.00
6.00	00600	MAINTENANCE & REPAIRS	69,940	433,392				6.00
7.00	00700	OPERATION OF PLANT	38,502	18,919	257,501			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,571	17,523	10,886	143,487		8.00
9.00	00900	HOUSEKEEPING	51,310	10,103	6,276	30,100	364,427	9.00
10.00	01000	DIETARY	42,501	20,284	12,602	616	19,108	10.00
11.00	01100	CAFETERIA	33,416	4,612	2,865	637	4,345	11.00
13.00	01300	NURSING ADMINISTRATION	40,076	9,663	6,004	0	9,103	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,972	24,911	15,477	0	23,468	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	50,003	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	310,029	68,553	42,590	102,094	64,580	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	76,023	33,053	20,535	3,227	31,137	50.00
53.00	05300	ANESTHESIOLOGY	1,221	455	283	0	429	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	232,156	37,712	23,430	369	35,526	54.00
60.00	06000	LABORATORY	222,474	18,605	11,559	54	17,527	60.00
65.00	06500	RESPIRATORY THERAPY	104,120	28,974	18,001	1,387	27,295	65.00
66.00	06600	PHYSICAL THERAPY	80,243	0	0	2,481	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,217	7,702	4,785	0	7,256	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	162,146	11,922	7,407	0	11,231	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	392,862	77,496	48,146	0	73,004	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	121,775	22,794	14,161	201	21,473	90.00
91.00	09100	EMERGENCY	198,409	20,111	12,494	2,275	18,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,368,966	433,392	257,501	143,441	364,427	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	140,728	0	0	46	0	192.00
192.01	19201	MARKETING	25,965	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,535,659	433,392	257,501	143,487	364,427	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part I Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			10.00	11.00	13.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	315,975					10.00
11.00	01100	CAFETERIA	0	219,525				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,360	277,466			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,964	0	474,232		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	309,853	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	315,975	55,011	158,673	54,904	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,640	22,036	24,781	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,378	309,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,921	0	113,928	0	54.00
60.00	06000	LABORATORY	0	25,609	0	93,711	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,547	9,468	29,459	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,112	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,566	0	23,217	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,596	0	45,516	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	36,325	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	15,208	43,864	19,543	0	90.00
91.00	09100	EMERGENCY	0	15,055	43,425	37,683	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	315,975	216,802	277,466	474,232	309,853	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MARKETING	0	2,723	0	0	0	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	315,975	219,525	277,466	474,232	309,853	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part I | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,783,519	0	2,783,519		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	613,494	0	613,494		50.00
53.00	05300	ANESTHESIOLOGY	329,964	0	329,964		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,664,473	0	1,664,473		54.00
60.00	06000	LABORATORY	1,545,658	0	1,545,658		60.00
65.00	06500	RESPIRATORY THERAPY	775,326	0	775,326		65.00
66.00	06600	PHYSICAL THERAPY	519,828	0	519,828		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	416,470	0	416,470		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,087,432	0	1,087,432		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,669,423	0	2,669,423		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	09000	CLINIC	891,840	0	891,840		90.00
91.00	09100	EMERGENCY	1,379,458	0	1,379,458		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,676,885	0	14,676,885		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	872,088	0	872,088		192.00
192.01	19201	MARKETING	163,621	0	163,621		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	15,712,594	0	15,712,594		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	79,201	65,994	145,195	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	19,970	16,640	36,610	0	6.00
7.00	00700	OPERATION OF PLANT	0	16,725	13,936	30,661	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,491	12,908	28,399	0	8.00
9.00	00900	HOUSEKEEPING	0	8,931	7,442	16,373	0	9.00
10.00	01000	DIETARY	0	17,932	14,941	32,873	0	10.00
11.00	01100	CAFETERIA	0	4,077	3,397	7,474	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,543	7,118	15,661	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,023	18,350	40,373	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	597	60,604	50,498	111,699	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	29,220	24,348	53,568	0	50.00
53.00	05300	ANESTHESIOLOGY	0	402	335	737	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,339	27,780	61,119	0	54.00
60.00	06000	LABORATORY	0	16,448	13,705	30,153	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,615	21,343	46,958	0	65.00
66.00	06600	PHYSICAL THERAPY	21,600	0	22,672	44,272	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,809	5,674	12,483	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,540	8,782	19,322	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,500	68,509	75,134	160,143	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,275	0	0	1,275	0	88.01
90.00	09000	CLINIC	112	20,150	16,790	37,052	0	90.00
91.00	09100	EMERGENCY	0	17,779	14,814	32,593	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,084	482,308	442,601	964,993	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,968	0	0	47,968	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	88,052	482,308	442,601	1,012,961	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	145,195					5.00
6.00	00600	MAINTENANCE & REPAIRS	4,005	40,615				6.00
7.00	00700	OPERATION OF PLANT	2,205	1,773	34,639			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,063	1,642	1,464	32,568		8.00
9.00	00900	HOUSEKEEPING	2,938	947	844	6,832	27,934	9.00
10.00	01000	DIETARY	2,434	1,901	1,695	140	1,465	10.00
11.00	01100	CAFETERIA	1,913	432	385	145	333	11.00
13.00	01300	NURSING ADMINISTRATION	2,295	906	808	0	698	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,663	2,335	2,082	0	1,799	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,863	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,753	6,424	5,729	23,173	4,950	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,353	3,098	2,762	732	2,387	50.00
53.00	05300	ANESTHESIOLOGY	70	43	38	0	33	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,294	3,534	3,152	84	2,723	54.00
60.00	06000	LABORATORY	12,739	1,744	1,555	12	1,343	60.00
65.00	06500	RESPIRATORY THERAPY	5,962	2,715	2,421	315	2,092	65.00
66.00	06600	PHYSICAL THERAPY	4,595	0	0	563	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,391	722	644	0	556	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,285	1,117	996	0	861	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	22,495	7,261	6,478	0	5,596	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	6,973	2,136	1,905	46	1,646	90.00
91.00	09100	EMERGENCY	11,361	1,885	1,681	516	1,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	135,650	40,615	34,639	32,558	27,934	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,058	0	0	10	0	192.00
192.01	19201	MARKETING	1,487	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	145,195	40,615	34,639	32,568	27,934	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part II Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			10.00	11.00	13.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	40,508					10.00
11.00	01100	CAFETERIA	0	10,682				11.00
13.00	01300	NURSING ADMINISTRATION	0	212	20,580			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	679	0	50,931		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	2,863	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,508	2,675	11,770	5,897		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	372	1,634	2,662		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,222		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	726	0	12,232		54.00
60.00	06000	LABORATORY	0	1,246	0	10,065		60.00
65.00	06500	RESPIRATORY THERAPY	0	757	702	3,164		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,160		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	320	0	2,494		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	321	0	4,889		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,768	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
90.00	09000	CLINIC	0	740	3,253	2,099		90.00
91.00	09100	EMERGENCY	0	733	3,221	4,047		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	40,508	10,549	20,580	50,931	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	MARKETING	0	133	0	0		192.01
200.00		Cross Foot Adjustments					2,863	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	40,508	10,682	20,580	50,931	2,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B Part II | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	230,578	0	230,578		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	71,568	0	71,568		50.00
53.00	05300	ANESTHESIOLOGY	2,143	0	2,143		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,864	0	96,864		54.00
60.00	06000	LABORATORY	58,857	0	58,857		60.00
65.00	06500	RESPIRATORY THERAPY	65,086	0	65,086		65.00
66.00	06600	PHYSICAL THERAPY	51,590	0	51,590		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,610	0	20,610		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,791	0	36,791		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	203,741	0	203,741		88.00
88.01	08801	RURAL HEALTH CLINIC II	1,275	0	1,275		88.01
90.00	09000	CLINIC	55,850	0	55,850		90.00
91.00	09100	EMERGENCY	57,489	0	57,489		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	952,442	0	952,442		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,036	0	56,036		192.00
192.01	19201	MARKETING	1,620	0	1,620		192.01
200.00		Cross Foot Adjustments	2,863	0	2,863		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,012,961	0	1,012,961		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	34,778					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		38,302				2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	7,307,612			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,711	5,711	924,058	-2,535,659	13,176,935	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,440	1,440	167,467	0	363,452	6.00
7.00	00700	OPERATION OF PLANT	1,206	1,206	0	0	200,080	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,117	1,117	42,997	0	96,507	8.00
9.00	00900	HOUSEKEEPING	644	644	163,760	0	266,638	9.00
10.00	01000	DIETARY	1,293	1,293	85,244	0	220,864	10.00
11.00	01100	CAFETERIA	294	294	87,820	0	173,650	11.00
13.00	01300	NURSING ADMINISTRATION	616	616	137,241	0	208,260	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,588	1,588	202,241	0	332,440	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	72,688	0	259,850	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,370	4,370	1,074,769	0	1,611,110	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,107	2,107	187,876	0	395,062	50.00
53.00	05300	ANESTHESIOLOGY	29	29	0	0	6,345	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,404	2,404	364,977	0	1,206,431	54.00
60.00	06000	LABORATORY	1,186	1,186	428,492	0	1,156,119	60.00
65.00	06500	RESPIRATORY THERAPY	1,847	1,847	316,258	0	541,075	65.00
66.00	06600	PHYSICAL THERAPY	0	1,962	135,526	0	416,992	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	491	491	96,303	0	307,727	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	760	179,349	0	842,614	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,940	6,502	1,320,343	0	2,041,590	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	1,453	1,453	344,571	0	632,821	90.00
91.00	09100	EMERGENCY	1,282	1,282	442,237	0	1,031,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,778	38,302	6,774,217	-2,535,659	12,310,688	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	448,002	0	731,314	192.00
192.01	19201	MARKETING	0	0	85,393	0	134,933	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	482,308	442,601	2,662,500		2,535,659	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.868193	11.555558	0.364346		0.192432	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		145,195	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.011019	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	27,627					6.00
7.00	00700	OPERATION OF PLANT	1,206	26,421				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,117	1,117	34,241			8.00
9.00	00900	HOUSEKEEPING	644	644	7,183	24,660		9.00
10.00	01000	DIETARY	1,293	1,293	147	1,293	2,736	10.00
11.00	01100	CAFETERIA	294	294	152	294	0	11.00
13.00	01300	NURSING ADMINISTRATION	616	616	0	616	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,588	1,588	0	1,588	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,370	4,370	24,363	4,370	2,736	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,107	2,107	770	2,107	0	50.00
53.00	05300	ANESTHESIOLOGY	29	29	0	29	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,404	2,404	88	2,404	0	54.00
60.00	06000	LABORATORY	1,186	1,186	13	1,186	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,847	1,847	331	1,847	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	592	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	491	491	0	491	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	760	760	0	760	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,940	4,940	0	4,940	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	1,453	1,453	48	1,453	0	90.00
91.00	09100	EMERGENCY	1,282	1,282	543	1,282	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,627	26,421	34,230	24,660	2,736	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	11	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	433,392	257,501	143,487	364,427	315,975	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.687262	9.746073	4.190503	14.778062	115.487939	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	40,615	34,639	32,568	27,934	40,508	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.470120	1.311040	0.951140	1.132766	14.805556	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet B-1 | Date/Time Prepared: 8/27/2013 2:25 pm

		Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			11.00	13.00	16.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	194,674					11.00
13.00	01300	NURSING ADMINISTRATION	3,866	85,307				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,383	0	30,740,474			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,784	48,784	3,558,923			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,775	6,775	1,606,367	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	737,532	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,232	0	7,385,070	0		54.00
60.00	06000	LABORATORY	22,710	0	6,074,491	0		60.00
65.00	06500	RESPIRATORY THERAPY	13,787	2,911	1,909,545	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,303,667	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,823	0	1,504,962	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,849	0	2,950,416	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	32,213	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0		88.01
90.00	09000	CLINIC	13,486	13,486	1,266,837	0		90.00
91.00	09100	EMERGENCY	13,351	13,351	2,442,664	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	192,259	85,307	30,740,474	100		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	MARKETING	2,415	0	0	0		192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	219,525	277,466	474,232	309,853		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.127654	3.252558	0.015427	3,098.530000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,682	20,580	50,931	2,863		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.054871	0.241246	0.001657	28.630000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet C Part I Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,783,519		2,783,519	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	613,494		613,494	0	0	50.00
53.00	05300	ANESTHESIOLOGY	329,964		329,964	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,664,473		1,664,473	0	0	54.00
60.00	06000	LABORATORY	1,545,658		1,545,658	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	775,326	0	775,326	0	0	65.00
66.00	06600	PHYSICAL THERAPY	519,828	0	519,828	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	416,470		416,470	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,087,432		1,087,432	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,669,423		2,669,423	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		0	0	0	88.01
90.00	09000	CLINIC	891,840		891,840	0	0	90.00
91.00	09100	EMERGENCY	1,379,458		1,379,458	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	386,745		386,745		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	15,063,630	0	15,063,630	0	0	200.00
201.00		Less Observation Beds	386,745		386,745		0	201.00
202.00		Total (see instructions)	14,676,885	0	14,676,885	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet C Part I Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,056,149		3,056,149			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	150,710	1,455,657	1,606,367	0.381914	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	64,907	672,625	737,532	0.447389	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	755,693	6,629,377	7,385,070	0.225384	0.000000	54.00
60.00	06000	LABORATORY	940,094	5,134,397	6,074,491	0.254451	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	687,118	1,222,427	1,909,545	0.406027	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	92,969	1,210,698	1,303,667	0.398743	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	945,308	559,654	1,504,962	0.276731	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,516,475	1,433,941	2,950,416	0.368569	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,280,511	2,280,511			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
90.00	09000	CLINIC	0	1,266,837	1,266,837	0.703990	0.000000	90.00
91.00	09100	EMERGENCY	78,908	2,363,756	2,442,664	0.564735	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	43,226	459,548	502,774	0.769222	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	8,331,557	24,689,428	33,020,985			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,331,557	24,689,428	33,020,985			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet C Part I Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part II Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,568	1,606,367	0.044553	38,959	1,736	50.00
53.00	05300	ANESTHESIOLOGY	2,143	737,532	0.002906	11,970	35	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,864	7,385,070	0.013116	387,282	5,080	54.00
60.00	06000	LABORATORY	58,857	6,074,491	0.009689	581,496	5,634	60.00
65.00	06500	RESPIRATORY THERAPY	65,086	1,909,545	0.034085	438,464	14,945	65.00
66.00	06600	PHYSICAL THERAPY	51,590	1,303,667	0.039573	54,428	2,154	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,610	1,504,962	0.013695	617,677	8,459	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,791	2,950,416	0.012470	924,037	11,523	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	203,741	2,280,511	0.089340	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,275	0	0.000000	0	0	88.01
90.00	09000	CLINIC	55,850	1,266,837	0.044086	0	0	90.00
91.00	09100	EMERGENCY	57,489	2,442,664	0.023535	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	502,774	0.000000	0	0	92.00
200.00		Total (lines 50-199)	721,864	29,964,836		3,054,313	49,566	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	309,853	0	0	0	309,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	309,853	0	0	0	309,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,606,367	0.000000	0.000000	38,959	50.00
53.00	05300	ANESTHESIOLOGY	0	737,532	0.420121	0.000000	11,970	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,385,070	0.000000	0.000000	387,282	54.00
60.00	06000	LABORATORY	0	6,074,491	0.000000	0.000000	581,496	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,909,545	0.000000	0.000000	438,464	65.00
66.00	06600	PHYSICAL THERAPY	0	1,303,667	0.000000	0.000000	54,428	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,504,962	0.000000	0.000000	617,677	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,950,416	0.000000	0.000000	924,037	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,280,511	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	1,266,837	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,442,664	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	502,774	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	29,964,836			3,054,313	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part IV | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	5,029	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	5,029	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part V Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.381914	0	718,650	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.447389	0	352,307	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225384	0	2,297,598	0	0	54.00
60.00	06000	LABORATORY	0.254451	0	2,492,276	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.406027	0	525,760	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.398743	0	394,774	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.276731	0	310,766	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368569	0	835,573	80	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	0.703990	0	1,263,205	0	0	90.00
91.00	09100	EMERGENCY	0.564735	0	785,538	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769222	0	271,662	0	0	92.00
200.00		Subtotal (see instructions)		0	10,248,109	80	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	10,248,109	80	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part V Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	274,462	0		50.00
53.00	05300	ANESTHESIOLOGY	157,618	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	517,842	0		54.00
60.00	06000	LABORATORY	634,162	0		60.00
65.00	06500	RESPIRATORY THERAPY	213,473	0		65.00
66.00	06600	PHYSICAL THERAPY	157,413	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,999	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	307,966	29		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	889,284	0		90.00
91.00	09100	EMERGENCY	443,621	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	208,968	0		92.00
200.00		Subtotal (see instructions)	3,890,808	29		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,890,808	29		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141324 | Component CCN: 14Z324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part V | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.381914	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.447389	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225384	0	0	0	0	54.00
60.00	06000	LABORATORY	0.254451	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.406027	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.398743	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.276731	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368569	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	0.703990	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.564735	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769222	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141324 | Component CCN: 14Z324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D Part V | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,467	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,215	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,736	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	170	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	59	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	19	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	4	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,890	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	170	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	57	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	121.01	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.03	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,783,519	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,299	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	528	25.00
26.00	Total swing-bed cost (see instructions)	187,722	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,595,797	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,471,227	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,471,227	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.747804	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,268.72	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,595,797	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	807.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,525,986	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,525,986	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	966,715	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,492,701	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	137,258	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	46,022	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	183,280	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	479	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	807.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	386,745	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-1 | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-3 | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,867,320		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.381914	38,959	14,879	50.00
53.00	05300	ANESTHESIOLOGY	0.447389	11,970	5,355	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225384	387,282	87,287	54.00
60.00	06000	LABORATORY	0.254451	581,496	147,962	60.00
65.00	06500	RESPIRATORY THERAPY	0.406027	438,464	178,028	65.00
66.00	06600	PHYSICAL THERAPY	0.398743	54,428	21,703	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.276731	617,677	170,930	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368569	924,037	340,571	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.703990	0	0	90.00
91.00	09100	EMERGENCY	0.564735	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769222	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,054,313	966,715	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,054,313		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet D-3

Component CCN: 14Z324 | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.381914	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.447389	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225384	15,869	3,577	54.00
60.00	06000	LABORATORY	0.254451	36,941	9,400	60.00
65.00	06500	RESPIRATORY THERAPY	0.406027	66,117	26,845	65.00
66.00	06600	PHYSICAL THERAPY	0.398743	26,876	10,717	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.276731	75,063	20,772	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.368569	97,360	35,884	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.703990	0	0	90.00
91.00	09100	EMERGENCY	0.564735	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.769222	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		318,226	107,195	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		318,226		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141324	Period: From 04/01/2012 To 03/31/2013	Worksheet E Part B Date/Time Prepared: 8/27/2013 2:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,890,837	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,890,837	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,929,745	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	44,598	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,546,684	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,338,463	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,338,463	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,338,463	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	529,355	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	529,355	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	415,891	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,867,818	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,867,818	40.00
41.00	Interim payments	2,606,470	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	261,348	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,208,984		2,668,086	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/12/2012	18,861		0	3.01
3.02		03/14/2013	20,602	03/14/2013	84,950	3.02
3.03		10/01/2012	46,653		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	12/12/2012	57,516	3.50
3.51			0	10/01/2012	89,050	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		86,116		-61,616	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,295,100		2,606,470	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		261,348	6.01
6.02	SETTLEMENT TO PROGRAM		52,962		0	6.02
7.00	Total Medicare program liability (see instructions)		2,242,138		2,867,818	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet E-1 Part I | Date/Time Prepared: 8/27/2013 2:25 pm

Component CCN: 14Z324 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		279,707		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/12/2012	36,148		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		36,148		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		315,855		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		23,659		0	6.02
7.00	Total Medicare program liability (see instructions)		292,196		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 141324 | Component CCN: 14Z324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet E-2 | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	185,113	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	108,267	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	227	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	293,380	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	293,380	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	293,380	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,184	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	292,196	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	292,196	0	19.00
20.00	Interim payments	315,855	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-23,659	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141324	Period: From 04/01/2012 To 03/31/2013	Worksheet E-3 Part V Date/Time Prepared: 8/27/2013 2:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,492,701	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,492,701	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,517,628	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,517,628	19.00
20.00	Deductibles (exclude professional component)	436,407	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	2,081,221	22.00
23.00	Coinsurance	578	23.00
24.00	Subtotal (line 22 minus line 23)	2,080,643	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	161,495	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	161,495	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	100,773	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,242,138	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,242,138	30.00
31.00	Interim payments	2,295,100	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	-52,962	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet G | Date/Time Prepared: 8/27/2013 2:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	489,402	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,717,341	0	0	0	4.00
5.00	Other receivable	107,597	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,513,695	0	0	0	6.00
7.00	Inventory	193,672	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	29,781	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,024,098	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	159,712	0	0	0	12.00
13.00	Land improvements	44,285	0	0	0	13.00
14.00	Accumulated depreciation	-27,310	0	0	0	14.00
15.00	Buildings	3,500,808	0	0	0	15.00
16.00	Accumulated depreciation	-908,099	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,401,461	0	0	0	23.00
24.00	Accumulated depreciation	-2,800,646	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,874	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	3,372,085	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,396,183	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,057,095	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,115,487	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	885,547	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	816,807	0	0	0	43.00
44.00	Other current liabilities	5	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,874,941	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	258,917	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	258,917	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	9,133,858	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,737,675				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,737,675	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,396,183	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet G-1 | Date/Time Prepared: 8/27/2013 2:25 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,190,307		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-547,368				2.00
3.00	Total (sum of line 1 and line 2)		-1,737,675		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,737,675		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,737,675		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/27/2013 2:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,968,453		2,968,453	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	78,996		78,996	5.00
6.00	Swing bed - NF	8,700		8,700	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,056,149		3,056,149	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,056,149		3,056,149	17.00
18.00	Ancillary services	5,153,274	18,318,776	23,472,050	18.00
19.00	Outpatient services	122,134	2,823,304	2,945,438	19.00
20.00	RURAL HEALTH CLINIC	0	1,761,674	1,761,674	20.00
20.01	RURAL HEALTH CLINIC II	0	1,785,674	1,785,674	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES AND NRCC REVENUES	100,753	2,218,859	2,319,612	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,432,310	26,908,287	35,340,597	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,733,100		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,733,100		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141324 | Period: From 04/01/2012 To 03/31/2013 | Worksheet G-3 | Date/Time Prepared: 8/27/2013 2:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	35,340,597	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,421,459	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,919,138	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,733,100	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,813,962	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	49,155	6.00
7.00	Income from investments	9,925	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	2,148	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	23,284	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	111,076	17.00
18.00	Revenue from sale of medical records and abstracts	10,877	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	4,212	21.00
22.00	Rental of hospital space	18,625	22.00
23.00	Governmental appropriations	504,406	23.00
24.00	MISCELLANEOUS INCOME	532,886	24.00
25.00	Total other income (sum of lines 6-24)	1,266,594	25.00
26.00	Total (line 5 plus line 25)	-547,368	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-547,368	29.00

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

Provider CCN: 141324 Component CCN: 148507 | Period: From 04/01/2012 To 03/31/2013 | Worksheet M-1 | Date/Time Prepared: 8/27/2013 2:25 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	622,022	0	622,022	0	622,022	1.00
2.00	Physician Assistant	215,000	0	215,000	45,775	260,775	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	294,143	0	294,143	17,691	311,834	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	1,131,165	0	1,131,165	63,466	1,194,631	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	280	280	0	280	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	280	280	0	280	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,131,165	280	1,131,445	63,466	1,194,911	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	17,775	17,775	0	17,775	29.00
30.00	Administrative Costs	103,986	96,126	200,112	21,727	221,839	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	103,986	113,901	217,887	21,727	239,614	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,235,151	114,181	1,349,332	85,193	1,434,525	32.00

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

Provider CCN: 141324 | Component CCN: 148507 | Period: From 04/01/2012 To 03/31/2013 | Worksheet M-1 | Date/Time Prepared: 8/27/2013 2:25 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	622,022		1.00
2.00	Physician Assistant	0	260,775		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	311,834		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	1,194,631		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	280		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	280		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,194,911		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	17,775		29.00
30.00	Administrative Costs	-17,640	204,199		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-17,640	221,974		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17,640	1,416,885		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 141324 | Component CCN: 148507 | Period: From 04/01/2012 To 03/31/2013 | Worksheet M-2 | Date/Time Prepared: 8/27/2013 2:25 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.81	11,022	4,200	11,802		1.00
2.00	Physician Assistant	2.54	6,457	2,100	5,334		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	5.35	17,479		17,136	17,479	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	5.35	17,479			17,479	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,194,911	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,194,911	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					221,974	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,252,538	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,474,512	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,474,512	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,474,512	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,669,423	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141324 | Component CCN: 148507 | Period: From 04/01/2012 To 03/31/2013 | Worksheet M-3 | Date/Time Prepared: 8/27/2013 2:25 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		2,669,423	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		33,944	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,635,479	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		17,479	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		17,479	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		150.78	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	78.54	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	150.78	150.78	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	3,635	1,212	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	548,085	182,745	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		730,830	16.00
16.01	Total program charges (see instructions)(from contractor's records)		410,237	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		555,731	16.04
16.05	Total program cost (see instructions)		555,731	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		36,166	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		74,814	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		555,731	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		18,554	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		574,285	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		574,285	26.00
27.00	Interim payments		444,833	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		129,452	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141324 Component CCN: 148507	Period: From 04/01/2012 To 03/31/2013	Worksheet M-4 Date/Time Prepared: 8/27/2013 2:25 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	1,194,631	1,194,631	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000212	0.002661	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	253	3,179	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,603	8,159	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,856	11,338	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,194,911	1,194,911	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	1,474,512	1,474,512	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003227	0.009489	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,758	13,992	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,614	25,330	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	58	820	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	148.52	30.89	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	33	442	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	4,901	13,653	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		33,944	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		18,554	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141324 Component CCN: 148507	Period: From 04/01/2012 To 03/31/2013	Worksheet M-5 Date/Time Prepared: 8/27/2013 2:25 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		475,640	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		12/12/2012	8,632	3.50
3.51		03/14/2013	3,303	3.51
3.52		12/12/2012	9,893	3.52
3.53		03/14/2013	8,979	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-30,807	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		444,833	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		129,452	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		574,285	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00