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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141301	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/21/2014 1:15 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2014 Time: 1:15 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 KIRBY HOSPITAL (141301) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 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	161,204	-1,969,880	91,765	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	241,645	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RHC #1 ATWOOD RURAL HEALTH CLINIC I	0		7,723		0	10.00
10.01	RHC #2 KIRBY MEDICAL GROUP RHC II	0		25,814		0	10.01
200.00	Total	0	402,849	-1,936,343	91,765	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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2014 1:14 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 MEDICAL CENTER DRIVE	PO Box:			1.00
2.00	City: MONTICELLO	State: IL	Zip Code: 61856	County: PIATT	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	KIRBY HOSPITAL	141301	16580	1	08/08/1999	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	KIRBY HOSPITAL - SWING BED	14Z301	16580		08/08/1999	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	ATWOOD RURAL HEALTH CLINIC	143438	16580		11/17/1997	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	KIRBY MEDICAL GROUP RHC	143495	16580		11/20/2008	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2013	06/30/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
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		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2014 1:14 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		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 this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 1:14 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

		Unweighted FTEs 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

		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 associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 1:14 pm

		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	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2014 1:14 pm

		V	XIX	
		1.00	2.00	
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.	N	N	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.	Y			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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	38,942	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 high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141301	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/21/2014 1:14 pm

		1.00	2.00	
	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

		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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	94,948	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2013	06/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2014 1:14 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)		N		N	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)		Y	10/22/2014	Y	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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2014 1:14 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				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	DANIEL	LARSEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5107-434-7055	DAN.LARSEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2014 1:14 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)				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)	10/22/2014			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.		PRINCIPAL		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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/21/2014 1:14 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)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	16	5,840	21,150.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		16	5,840	21,150.00	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)		16	5,840	21,150.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC #1 ATWOOD RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RHC #2 KIRBY MEDICAL GROUP RHC	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		16				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)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 1:14 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)(see instructions for col. 2 for the portion of LDP room available beds)	382	51	669			1.00
2.00	HMO and other (see instructions)	128	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	503	0	778			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	232			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	885	51	1,679			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)	885	51	1,679	0.00	152.59	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC #1 ATWOOD RURAL HEALTH CLINIC	578	0	5,065	0.00	6.86	26.00
26.01	RHC #2 KIRBY MEDICAL GROUP RHC	2,589	0	14,436	0.00	20.84	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	180.29	27.00
28.00	Observation Bed Days		0	109			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	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2014 1:14 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)(see instructions for col. 2 for the portion of LDP room available beds)		0	127	15	223	1.00
2.00	HMO and other (see instructions)			41	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	127	15	223	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC #1 ATWOOD RURAL HEALTH CLINIC	0.00					26.00
26.01	RHC #2 KIRBY MEDICAL GROUP RHC	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
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141301 Component CCN: 143438 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-8 Date/Time Prepared: 11/21/2014 1:14 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	108 SOUTH MAIN STREET	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	ATWOOD	IL	61913	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			08:30	17:00	08:30	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. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

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

			County				
			4.00				
2.00	City, State, Zip Code, County		DOUGLAS				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	17:00	08:30	17:00	08:30	17:00	11.00

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

Provider CCN: 141301
Component CCN: 143438

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-8

Date/Time Prepared:
11/21/2014 1:14 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	08:30	16:00				11.00

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

Provider CCN: 141301 Component CCN: 143495 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-8 Date/Time Prepared: 11/21/2014 1:14 pm

Rural Health Clinic (RHC) II | Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				1000 MEDICAL CENTER DRIVE		1.00
		City			State	Zip Code	
		1.00			2.00	3.00	
2.00	City, State, Zip Code, County	MONTICELLO			IL	61856	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			07:00	18:00	07:00	11.00

					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	Provider name, CCN number						14.00

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

			County				
			4.00				
2.00	City, State, Zip Code, County		PIATT				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	18:00	07:00	18:00	07:00	18:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141301 Component CCN: 143495	Period: From 07/01/2013 To 06/30/2014	Worksheet S-8 Date/Time Prepared: 11/21/2014 1:14 pm
		Rural Health Clinic (RHC) II	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 11/21/2014 1:14 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)	0.473868	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,751,882	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	5,790,824	6.00
7.00	Medicaid cost (line 1 times line 6)	2,744,086	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)	0	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)	0	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	1,252,709	228,224	1,480,933	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	593,619	108,148	701,767	21.00
22.00	Partial payment by patients approved for charity care	17,777	0	17,777	22.00
23.00	Cost of charity care (line 21 minus line 22)	575,842	108,148	683,990	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)	695,110	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	187,246	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	507,864	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	240,660	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	924,650	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	924,650	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 1:14 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		3,536,027	3,536,027	58,215	3,594,242	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,540,578	1,540,578	43,022	1,583,600	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	137,738	137,738	0	137,738	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,136,760	3,068,244	5,205,004	-37,823	5,167,181	5.00
6.00	00600	MAINTENANCE & REPAIRS	190,753	251,395	442,148	0	442,148	6.00
7.00	00700	OPERATION OF PLANT	0	349,339	349,339	0	349,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	70,972	70,972	8.00
9.00	00900	HOUSEKEEPING	278,788	107,843	386,631	-3,060	383,571	9.00
10.00	01000	DIETARY	231,560	181,915	413,475	-357,754	55,721	10.00
11.00	01100	CAFETERIA	0	0	0	357,754	357,754	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	79,988	27,076	107,064	0	107,064	14.00
15.00	01500	PHARMACY	59,001	167,677	226,678	0	226,678	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	461,098	255,486	716,584	0	716,584	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,045,768	570,363	1,616,131	80,769	1,696,900	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	357,990	662,589	1,020,579	-12,877	1,007,702	50.00
53.00	05300	ANESTHESIOLOGY	140,007	18,853	158,860	0	158,860	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	574,958	816,417	1,391,375	-1,394	1,389,981	54.00
56.00	03630	ULTRA SOUND	0	12,258	12,258	0	12,258	56.00
60.00	06000	LABORATORY	494,702	1,025,528	1,520,230	-2,721	1,517,509	60.00
66.00	06600	PHYSICAL THERAPY	462,678	169,948	632,626	-1,394	631,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	166,076	48,171	214,247	0	214,247	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,275	15,275	0	15,275	68.00
69.00	06900	ELECTROCARDIOLOGY	16,500	4,123	20,623	8,006	28,629	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	151,526	151,526	0	151,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,428	24,428	0	24,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	317,024	317,024	0	317,024	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	348,560	190,452	539,012	-29,823	509,189	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	1,439,089	823,278	2,262,367	-149,937	2,112,430	88.01
91.00	09100	EMERGENCY	781,963	2,084,595	2,866,558	-76,848	2,789,710	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	282,835	166,301	449,136	54,893	504,029	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,549,074	16,724,447	26,273,521	0	26,273,521	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	9,549,074	16,724,447	26,273,521	0	26,273,521	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/21/2014 1:14 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	-50,448	3,543,794		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-694,045	889,555		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	137,738		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-457,623	4,709,558		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	442,148		6.00
7.00	00700	OPERATION OF PLANT	8,435	357,774		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,972		8.00
9.00	00900	HOUSEKEEPING	0	383,571		9.00
10.00	01000	DIETARY	0	55,721		10.00
11.00	01100	CAFETERIA	-123,830	233,924		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	107,064		14.00
15.00	01500	PHARMACY	0	226,678		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-397	716,187		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-140,631	1,556,269		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-169,649	838,053		50.00
53.00	05300	ANESTHESIOLOGY	0	158,860		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-284,868	1,105,113		54.00
56.00	03630	ULTRA SOUND	0	12,258		56.00
60.00	06000	LABORATORY	0	1,517,509		60.00
66.00	06600	PHYSICAL THERAPY	-70,990	560,242		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	214,247		67.00
68.00	06800	SPEECH PATHOLOGY	0	15,275		68.00
69.00	06900	ELECTROCARDIOLOGY	-16,500	12,129		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	151,526		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,428		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	317,024		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	509,189		88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	2,112,430		88.01
91.00	09100	EMERGENCY	-1,123,521	1,666,189		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-175	503,854		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,124,242	23,149,279		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,287	12,287		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,111,955	23,161,566		200.00

RECLASSIFICATIONS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 1:14 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	58,215	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,886	2.00
	TOTALS		0	74,101	
	B - CAPITAL LEASE INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	27,136	1.00
	TOTALS		0	27,136	
	D - CAFETERIA				
1.00	CAFETERIA	11.00	200,354	157,400	1.00
	TOTALS		200,354	157,400	
	E - EKG				
1.00	ELECTROCARDIOLOGY	69.00	6,388	1,618	1.00
2.00		0.00	0	0	2.00
	TOTALS		6,388	1,618	
	F - CASE MANAGEMENT				
1.00	ADULTS & PEDIATRICS	30.00	92,111	22,841	1.00
	TOTALS		92,111	22,841	
	G - AMBULANCE				
1.00	AMBULANCE SERVICES	95.00	56,029	0	1.00
	TOTALS		56,029	0	
	H - RHC ADMITTING				
1.00	ADMINISTRATIVE & GENERAL	5.00	121,000	31,951	1.00
2.00		0.00	0	0	2.00
	TOTALS		121,000	31,951	
	I - CHIEF MEDICAL OFFICER				
1.00	ADMINISTRATIVE & GENERAL	5.00	20,250	5,165	1.00
	TOTALS		20,250	5,165	
	J - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	70,972	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	70,972	
500.00	Grand Total: Increases		496,132	391,184	500.00

RECLASSIFICATIONS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/21/2014 1:14 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	74,101	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	74,101			
	B - CAPITAL LEASE INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,136	11		1.00
	TOTALS		0	27,136			
	D - CAFETERIA						
1.00	DIETARY	10.00	200,354	157,400	0		1.00
	TOTALS		200,354	157,400			
	E - EKG						
1.00	LABORATORY	60.00	2,200	521	0		1.00
2.00	EMERGENCY	91.00	4,188	1,097	0		2.00
	TOTALS		6,388	1,618			
	F - CASE MANAGEMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	92,111	22,841	0		1.00
	TOTALS		92,111	22,841			
	G - AMBULANCE						
1.00	EMERGENCY	91.00	56,029	0	0		1.00
	TOTALS		56,029	0			
	H - RHC ADMITTING						
1.00	RHC #1 ATWOOD RURAL HEALTH CLINIC	88.00	23,593	6,230	0		1.00
2.00	RHC #2 KIRBY MEDICAL GROUP RHC	88.01	97,407	25,721	0		2.00
	TOTALS		121,000	31,951			
	I - CHIEF MEDICAL OFFICER						
1.00	RHC #2 KIRBY MEDICAL GROUP RHC	88.01	20,250	5,165	0		1.00
	TOTALS		20,250	5,165			
	J - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	3,060	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	34,183	0		2.00
3.00	OPERATING ROOM	50.00	0	12,877	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,394	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	1,394	0		5.00
6.00	RHC #2 KIRBY MEDICAL GROUP RHC	88.01	0	1,394	0		6.00
7.00	EMERGENCY	91.00	0	15,534	0		7.00
8.00	AMBULANCE SERVICES	95.00	0	1,136	0		8.00
	TOTALS		0	70,972			
500.00	Grand Total: Decreases		496,132	391,184			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2014 1:14 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	349,650	0	0	0	0	1.00
2.00	Land Improvements	4,579,613	67,471	0	67,471	0	2.00
3.00	Buildings and Fixtures	15,936,722	15,855	0	15,855	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	9,912,505	90,853	0	90,853	0	5.00
6.00	Movable Equipment	5,329,503	491,884	0	491,884	263,315	6.00
7.00	HIT designated Assets	2,829,186	58,988	0	58,988	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,937,179	725,051	0	725,051	263,315	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	38,937,179	725,051	0	725,051	263,315	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	349,650	0	1.00
2.00	Land Improvements	4,647,084	0	2.00
3.00	Buildings and Fixtures	15,952,577	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	10,003,358	0	5.00
6.00	Movable Equipment	5,558,072	0	6.00
7.00	HIT designated Assets	2,888,174	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,398,915	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	39,398,915	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2014 1:14 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	1,853,992	0	1,682,035	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,540,578	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,394,570	0	1,682,035	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3,536,027	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,540,578	2.00
3.00	Total (sum of lines 1-2)	0	5,076,605	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III | Date/Time Prepared: 11/21/2014 1:14 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	30,952,669	0	30,952,669	0.785622	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,446,246	0	8,446,246	0.214378	0	2.00
3.00	Total (sum of lines 1-2)	39,398,915	0	39,398,915	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	0	1,853,992	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	847,347	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,701,339	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	1,631,587	58,215	0	0	3,543,794	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,322	15,886	0	0	889,555	2.00
3.00	Total (sum of lines 1-2)	1,657,909	74,101	0	0	4,433,349	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 1:14 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	-50,448	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-814	CAP REL COSTS-MVBLE EQUIP	2.00	11	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)		0		0.00	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)	A	-3,852	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,735,169			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	-123,830	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-397	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		0		0.00	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-693,231	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-3,546	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/21/2014 1:14 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	
33.01	MISCELLANEOUS INCOME - AMBULANCE	B	-175	AMBULANCE SERVICES	95.00	0	33.01
33.02	CANCER CLINIC INCOME	B	-15,801	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PHASE III CARDIAC REHAB INCOME	B	-70,990	PHYSICAL THERAPY	66.00	0	33.03
33.04	NON-ALLOWABLE ADVERTISING	A	-14,031	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	NON-ALLOWABLE LOBBYING	A	-7,567	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PROPERTY TAX	A	-17,332	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-391,654	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	KEY EMPLOYEE LIFE INSURANCE	A	-14,448	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TRUST DEPR HOSPITAL ADMINISTRATION	A	6,756	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	TRUST DEPR OPERATION OF PLANT	A	12,287	OPERATION OF PLANT	7.00	0	33.10
33.11	TRUST DEPR PHYSICIAN PRIVATE OFFICES	A	12,287	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,111,955				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2014 1:14 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	30.00	ADULTS & PEDIATRICS	140,631	140,631	0	0	0	1.00
2.00	50.00	OPERATING ROOM	169,649	169,649	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	284,868	284,868	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	16,500	16,500	0	0	0	4.00
5.00	91.00	EMERGENCY	1,797,346	1,123,521	673,825	0	0	5.00
6.00	88.00	RHC #1 ATWOOD RURAL HEALTH CLINIC	159,786	0	159,786	0	0	6.00
7.00	88.01	RHC #2 KIRBY MEDICAL GROUP RHC	892,404	0	892,404	0	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	20,250	0	20,250	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			3,481,434	1,735,169	1,746,265		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	88.00	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	0	0	0	0	6.00
7.00	88.01	RHC #2 KIRBY MEDICAL GROUP RHC	0	0	0	0	0	7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	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	30.00	ADULTS & PEDIATRICS	0	0	0	140,631		1.00
2.00	50.00	OPERATING ROOM	0	0	0	169,649		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	284,868		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	16,500		4.00
5.00	91.00	EMERGENCY	0	0	0	1,123,521		5.00
6.00	88.00	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	0	0	0		6.00
7.00	88.01	RHC #2 KIRBY MEDICAL GROUP RHC	0	0	0	0		7.00
8.00	5.00	ADMINISTRATIVE & GENERAL	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	1,735,169		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2014 1:14 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					49	1.00
2.00	Line 1 multiplied by 15 hours per week					735	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					92	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					5.63	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	235.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.80	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)	34.90	34.90	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)					16,403	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)					16,403	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)					16,403	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)					69.80	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					51,303	22.00
23.00	Total salary equivalency (see instructions)					51,303	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)					3,211	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)					3,211	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)					518	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,729	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,729	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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2014 1:14 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)	69.80	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)	51,303	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,729	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)	55,032	63.00
64.00	Total cost of outside supplier services (from your records)	15,275	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	3,211	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	518	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,729	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	518	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	518	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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 1:14 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,543,794	3,543,794				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	889,555		889,555			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	137,738	0	0	137,738		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,709,558	248,534	209,770	31,533	5,199,395	5.00
6.00	00600	MAINTENANCE & REPAIRS	442,148	13,378	5,636	2,751	463,913	6.00
7.00	00700	OPERATION OF PLANT	357,774	711,960	60,322	0	1,130,056	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,972	15,657	0	0	86,629	8.00
9.00	00900	HOUSEKEEPING	383,571	58,913	668	4,021	447,173	9.00
10.00	01000	DIETARY	55,721	122,781	37,395	450	216,347	10.00
11.00	01100	CAFETERIA	233,924	58,269	0	2,890	295,083	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107,064	62,629	1,019	1,154	171,866	14.00
15.00	01500	PHARMACY	226,678	52,868	0	851	280,397	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	716,187	77,989	13,494	6,651	814,321	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,556,269	485,276	60,921	16,413	2,118,879	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	838,053	399,558	59,200	5,164	1,301,975	50.00
53.00	05300	ANESTHESIOLOGY	158,860	0	0	2,019	160,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,105,113	178,126	308,715	8,293	1,600,247	54.00
56.00	03630	ULTRA SOUND	12,258	6,243	36,638	0	55,139	56.00
60.00	06000	LABORATORY	1,517,509	68,624	24,230	7,104	1,617,467	60.00
66.00	06600	PHYSICAL THERAPY	560,242	213,801	10,581	6,674	791,298	66.00
67.00	06700	OCCUPATIONAL THERAPY	214,247	0	0	2,395	216,642	67.00
68.00	06800	SPEECH PATHOLOGY	15,275	0	0	0	15,275	68.00
69.00	06900	ELECTROCARDIOLOGY	12,129	0	0	330	12,459	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,526	0	0	0	151,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,428	0	0	0	24,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,024	0	0	0	317,024	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	509,189	30,670	1,641	4,687	546,187	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	2,112,430	368,094	17,352	19,060	2,516,936	88.01
91.00	09100	EMERGENCY	1,666,189	311,907	19,506	10,410	2,008,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	503,854	42,909	22,467	4,888	574,118	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,149,279	3,528,186	889,555	137,738	23,133,671	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,608	0	0	15,608	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,287	0	0	0	12,287	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,161,566	3,543,794	889,555	137,738	23,161,566	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/21/2014 1:14 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 DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,199,395					5.00
6.00	00600	MAINTENANCE & REPAIRS	134,286	598,199				6.00
7.00	00700	OPERATION OF PLANT	327,111	129,771	1,586,938			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,076	2,854	9,785	124,344		8.00
9.00	00900	HOUSEKEEPING	129,440	10,738	36,818	5,361	629,530	9.00
10.00	01000	DIETARY	62,625	22,380	76,733	0	30,975	10.00
11.00	01100	CAFETERIA	85,416	10,621	36,416	0	14,700	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	49,749	11,416	39,141	0	15,800	14.00
15.00	01500	PHARMACY	81,165	9,636	33,041	0	13,338	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	235,717	14,215	48,740	0	19,675	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	613,339	88,453	303,280	59,891	122,425	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	376,875	72,829	249,709	22,560	100,801	50.00
53.00	05300	ANESTHESIOLOGY	46,569	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,214	32,468	111,322	2,442	44,938	54.00
56.00	03630	ULTRA SOUND	15,961	1,138	3,902	0	1,575	56.00
60.00	06000	LABORATORY	468,198	12,508	42,888	0	17,313	60.00
66.00	06600	PHYSICAL THERAPY	229,052	38,970	133,618	2,442	53,938	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,710	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,422	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,606	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,861	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,071	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,767	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	158,101	5,590	0	0	7,738	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	728,556	67,094	230,045	2,442	92,863	88.01
91.00	09100	EMERGENCY	581,247	56,852	194,930	27,216	78,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	166,186	7,821	26,816	1,990	10,825	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,191,320	595,354	1,577,184	124,344	625,592	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,518	2,845	9,754	0	3,938	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,557	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,199,395	598,199	1,586,938	124,344	629,530	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 1:14 pm

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	409,060					10.00
11.00	01100	CAFETERIA	0	442,236				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,581	296,553			14.00
15.00	01500	PHARMACY	0	4,096	313	421,986		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47,118	1,386	0	1,181,172	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	409,060	77,932	7,030	0	238,609	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	24,495	44,983	0	137,704	50.00
53.00	05300	ANESTHESIOLOGY	0	1,521	709	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,253	4,701	0	128,208	54.00
56.00	03630	ULTRA SOUND	0	0	375	0	30,865	56.00
60.00	06000	LABORATORY	0	41,189	86,077	0	157,885	60.00
66.00	06600	PHYSICAL THERAPY	0	26,679	2,191	0	46,297	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,191	0	0	4,748	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2,374	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	124	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	29,633	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,777	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	61,998	421,986	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	0	8,992	0	0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	81,285	36,524	0	1,187	88.01
91.00	09100	EMERGENCY	0	65,645	3,600	0	378,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,251	3,140	0	54,607	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	409,060	442,236	296,553	421,986	1,181,172	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	409,060	442,236	296,553	421,986	1,181,172	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/21/2014 1:14 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 DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,038,898	0	4,038,898		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,331,931	0	2,331,931		50.00
53.00	05300	ANESTHESIOLOGY	209,678	0	209,678		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,427,793	0	2,427,793		54.00
56.00	03630	ULTRA SOUND	108,955	0	108,955		56.00
60.00	06000	LABORATORY	2,443,525	0	2,443,525		60.00
66.00	06600	PHYSICAL THERAPY	1,324,485	0	1,324,485		66.00
67.00	06700	OCCUPATIONAL THERAPY	292,291	0	292,291		67.00
68.00	06800	SPEECH PATHOLOGY	22,071	0	22,071		68.00
69.00	06900	ELECTROCARDIOLOGY	16,189	0	16,189		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	225,020	0	225,020		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,276	0	36,276		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	892,775	0	892,775		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	726,608	0	726,608		88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	3,756,932	0	3,756,932		88.01
91.00	09100	EMERGENCY	3,394,878	0	3,394,878		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	860,754	0	860,754		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,109,059	0	23,109,059		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,663	0	36,663		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,844	0	15,844		192.00
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)	23,161,566	0	23,161,566		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 1:14 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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 DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	248,534	209,770	458,304	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	13,378	5,636	19,014	0	6.00
7.00	00700	OPERATION OF PLANT	0	711,960	60,322	772,282	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,657	0	15,657	0	8.00
9.00	00900	HOUSEKEEPING	0	58,913	668	59,581	0	9.00
10.00	01000	DIETARY	0	122,781	37,395	160,176	0	10.00
11.00	01100	CAFETERIA	0	58,269	0	58,269	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	62,629	1,019	63,648	0	14.00
15.00	01500	PHARMACY	0	52,868	0	52,868	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	77,989	13,494	91,483	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	485,276	60,921	546,197	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	399,558	59,200	458,758	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	178,126	308,715	486,841	0	54.00
56.00	03630	ULTRA SOUND	0	6,243	36,638	42,881	0	56.00
60.00	06000	LABORATORY	0	68,624	24,230	92,854	0	60.00
66.00	06600	PHYSICAL THERAPY	0	213,801	10,581	224,382	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	30,670	1,641	32,311	0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	368,094	17,352	385,446	0	88.01
91.00	09100	EMERGENCY	0	311,907	19,506	331,413	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	42,909	22,467	65,376	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,528,186	889,555	4,417,741	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,608	0	15,608	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,543,794	889,555	4,433,349	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 1:14 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 DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	458,304					5.00
6.00	00600	MAINTENANCE & REPAIRS	11,837	30,851				6.00
7.00	00700	OPERATION OF PLANT	28,833	6,693	807,808			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,210	147	4,981	22,995		8.00
9.00	00900	HOUSEKEEPING	11,410	554	18,742	991	91,278	9.00
10.00	01000	DIETARY	5,520	1,154	39,060	0	4,491	10.00
11.00	01100	CAFETERIA	7,529	548	18,537	0	2,131	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,385	589	19,924	0	2,291	14.00
15.00	01500	PHARMACY	7,154	497	16,819	0	1,934	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,777	733	24,811	0	2,853	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,063	4,562	154,380	11,075	17,750	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,220	3,756	127,111	4,172	14,616	50.00
53.00	05300	ANESTHESIOLOGY	4,105	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,830	1,674	56,667	452	6,516	54.00
56.00	03630	ULTRA SOUND	1,407	59	1,986	0	228	56.00
60.00	06000	LABORATORY	41,270	645	21,831	0	2,510	60.00
66.00	06600	PHYSICAL THERAPY	20,190	2,010	68,016	452	7,821	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,528	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	390	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	318	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,866	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	623	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,089	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	13,936	288	0	0	1,122	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	64,219	3,460	117,101	452	13,465	88.01
91.00	09100	EMERGENCY	51,234	2,932	99,226	5,033	11,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	14,649	403	13,651	368	1,570	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	457,592	30,704	802,843	22,995	90,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	398	147	4,965	0	571	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	314	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	458,304	30,851	807,808	22,995	91,278	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 1:14 pm

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	210,401					10.00
11.00	01100	CAFETERIA	0	87,014				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,688	92,525			14.00
15.00	01500	PHARMACY	0	806	98	80,176		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,271	432	0	150,360	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	210,401	15,334	2,193	0	30,374	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,820	14,035	0	17,529	50.00
53.00	05300	ANESTHESIOLOGY	0	299	221	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,920	1,467	0	16,320	54.00
56.00	03630	ULTRA SOUND	0	0	117	0	3,929	56.00
60.00	06000	LABORATORY	0	8,104	26,856	0	20,098	60.00
66.00	06600	PHYSICAL THERAPY	0	5,249	684	0	5,894	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,612	0	0	604	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	302	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	39	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9,245	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,490	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	19,343	80,176	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	0	2,806	0	0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	15,994	11,396	0	151	88.01
91.00	09100	EMERGENCY	0	12,916	1,123	0	48,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,001	980	0	6,951	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	210,401	87,014	92,525	80,176	150,360	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	210,401	87,014	92,525	80,176	150,360	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/21/2014 1:14 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 DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,046,329	0	1,046,329		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	678,017	0	678,017		50.00
53.00	05300	ANESTHESIOLOGY	4,625	0	4,625		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	618,687	0	618,687		54.00
56.00	03630	ULTRA SOUND	50,607	0	50,607		56.00
60.00	06000	LABORATORY	214,168	0	214,168		60.00
66.00	06600	PHYSICAL THERAPY	334,698	0	334,698		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,744	0	7,744		67.00
68.00	06800	SPEECH PATHOLOGY	692	0	692		68.00
69.00	06900	ELECTROCARDIOLOGY	357	0	357		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,111	0	13,111		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,113	0	2,113		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,608	0	107,608		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	50,463	0	50,463		88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	611,684	0	611,684		88.01
91.00	09100	EMERGENCY	563,494	0	563,494		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	106,949	0	106,949		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,411,346	0	4,411,346		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,689	0	21,689		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	314	0	314		192.00
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)	4,433,349	0	4,433,349		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 1:14 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (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	71,522					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		847,346				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	9,549,074			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,016	199,817	2,185,899	-5,199,395	17,962,171	5.00
6.00	00600	MAINTENANCE & REPAIRS	270	5,369	190,753	0	463,913	6.00
7.00	00700	OPERATION OF PLANT	14,369	57,460	0	0	1,130,056	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	0	0	0	86,629	8.00
9.00	00900	HOUSEKEEPING	1,189	636	278,788	0	447,173	9.00
10.00	01000	DIETARY	2,478	35,621	31,206	0	216,347	10.00
11.00	01100	CAFETERIA	1,176	0	200,354	0	295,083	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,264	971	79,988	0	171,866	14.00
15.00	01500	PHARMACY	1,067	0	59,001	0	280,397	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,574	12,854	461,098	0	814,321	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,794	58,030	1,137,879	0	2,118,879	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,064	56,391	357,990	0	1,301,975	50.00
53.00	05300	ANESTHESIOLOGY	0	0	140,007	0	160,879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,595	294,065	574,958	0	1,600,247	54.00
56.00	03630	ULTRA SOUND	126	34,900	0	0	55,139	56.00
60.00	06000	LABORATORY	1,385	23,080	492,502	0	1,617,467	60.00
66.00	06600	PHYSICAL THERAPY	4,315	10,079	462,678	0	791,298	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	166,076	0	216,642	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	15,275	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	22,888	0	12,459	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	151,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	24,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	317,024	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	619	1,563	324,967	0	546,187	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	7,429	16,529	1,321,432	0	2,516,936	88.01
91.00	09100	EMERGENCY	6,295	18,580	721,746	0	2,008,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	21,401	338,864	0	574,118	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,207	847,346	9,549,074	-5,199,395	17,934,276	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	0	0	0	15,608	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	12,287	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,543,794	889,555	137,738		5,199,395	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.548307	1.049813	0.014424		0.289464	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		458,304	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.025515	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 1:14 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	66,236					6.00
7.00	00700	OPERATION OF PLANT	14,369	51,248				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	316	82,525			8.00
9.00	00900	HOUSEKEEPING	1,189	1,189	3,558	50,362		9.00
10.00	01000	DIETARY	2,478	2,478	0	2,478	6,125	10.00
11.00	01100	CAFETERIA	1,176	1,176	0	1,176	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,264	1,264	0	1,264	0	14.00
15.00	01500	PHARMACY	1,067	1,067	0	1,067	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,574	1,574	0	1,574	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,794	9,794	39,747	9,794	6,125	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,064	8,064	14,973	8,064	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,595	3,595	1,621	3,595	0	54.00
56.00	03630	ULTRA SOUND	126	126	0	126	0	56.00
60.00	06000	LABORATORY	1,385	1,385	0	1,385	0	60.00
66.00	06600	PHYSICAL THERAPY	4,315	4,315	1,621	4,315	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	619	0	0	619	0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	7,429	7,429	1,621	7,429	0	88.01
91.00	09100	EMERGENCY	6,295	6,295	18,063	6,295	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	866	1,321	866	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,921	50,933	82,525	50,047	6,125	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	315	0	315	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	598,199	1,586,938	124,344	629,530	409,060	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.031327	30.965852	1.506743	12.500099	66.785306	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,851	807,808	22,995	91,278	210,401	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.465774	15.762722	0.278643	1.812438	34.351184	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/21/2014 1:14 pm

		Cost Center Description	CAFETERIA (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			11.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,338					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	220	1,516,425				14.00
15.00	01500	PHARMACY	105	1,598	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,208	7,087	0	995		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,998	35,947	0	201		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	628	230,018	0	116		50.00
53.00	05300	ANESTHESIOLOGY	39	3,623	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,032	24,038	0	108		54.00
56.00	03630	ULTRA SOUND	0	1,919	0	26		56.00
60.00	06000	LABORATORY	1,056	440,161	0	133		60.00
66.00	06600	PHYSICAL THERAPY	684	11,206	0	39		66.00
67.00	06700	OCCUPATIONAL THERAPY	210	0	0	4		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2		68.00
69.00	06900	ELECTROCARDIOLOGY	0	636	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	151,526	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,428	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	317,024	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	45,982	0	0		88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	2,084	186,766	0	1		88.01
91.00	09100	EMERGENCY	1,683	18,411	0	319		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	391	16,055	0	46		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,338	1,516,425	100	995		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	442,236	296,553	421,986	1,181,172		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.004763	0.195561	4,219.860000	1,187.107538		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	87,014	92,525	80,176	150,360		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.674546	0.061015	801.760000	151.115578		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 1:14 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	4,038,898		4,038,898	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,331,931		2,331,931	0	0	50.00
53.00	05300	ANESTHESIOLOGY	209,678		209,678	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,427,793		2,427,793	0	0	54.00
56.00	03630	ULTRA SOUND	108,955		108,955	0	0	56.00
60.00	06000	LABORATORY	2,443,525		2,443,525	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,324,485	0	1,324,485	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	292,291	0	292,291	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,071	0	22,071	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16,189		16,189	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	225,020		225,020	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,276		36,276	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	892,775		892,775	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	726,608		726,608	0	0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	3,756,932		3,756,932	0	0	88.01
91.00	09100	EMERGENCY	3,394,878		3,394,878	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	280,745		280,745		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	860,754		860,754	0	0	95.00
200.00		Subtotal (see instructions)	23,389,804	0	23,389,804	0	0	200.00
201.00		Less Observation Beds	280,745		280,745		0	201.00
202.00		Total (see instructions)	23,109,059	0	23,109,059	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 1:14 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	2,978,669		2,978,669			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	113,804	5,670,093	5,783,897	0.403176	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	28,664	618,145	646,809	0.324173	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	161,684	6,459,116	6,620,800	0.366692	0.000000	54.00
56.00	03630	ULTRA SOUND	80,660	871,881	952,541	0.114384	0.000000	56.00
60.00	06000	LABORATORY	561,044	10,782,021	11,343,065	0.215420	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	266,106	3,177,448	3,443,554	0.384627	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,252	145,232	294,484	0.992553	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	20,582	48,770	69,352	0.318246	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,957	415,612	429,569	0.037687	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	393,436	865,442	1,258,878	0.178746	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	139,286	139,286	0.260443	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,033,217	2,901,815	3,935,032	0.226879	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	1,021,903	1,021,903			88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	2,614,378	2,614,378			88.01
91.00	09100	EMERGENCY	1,230	4,964,375	4,965,605	0.683679	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	230,195	230,195	1.219596	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,038,873	2,038,873	0.422171	0.000000	95.00
200.00		Subtotal (see instructions)	5,802,305	42,964,585	48,766,890			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,802,305	42,964,585	48,766,890			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/21/2014 1:14 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
56.00	03630	ULTRA SOUND	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC		88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC		88.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/21/2014 1:14 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	678,017	5,783,897	0.117225	31,967	3,747	50.00
53.00	05300	ANESTHESIOLOGY	4,625	646,809	0.007150	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	618,687	6,620,800	0.093446	41,943	3,919	54.00
56.00	03630	ULTRA SOUND	50,607	952,541	0.053128	26,894	1,429	56.00
60.00	06000	LABORATORY	214,168	11,343,065	0.018881	205,853	3,887	60.00
66.00	06600	PHYSICAL THERAPY	334,698	3,443,554	0.097196	35,902	3,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,744	294,484	0.026297	5,021	132	67.00
68.00	06800	SPEECH PATHOLOGY	692	69,352	0.009978	7,000	70	68.00
69.00	06900	ELECTROCARDIOLOGY	357	429,569	0.000831	5,386	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,111	1,258,878	0.010415	136,350	1,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,113	139,286	0.015170	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,608	3,935,032	0.027346	328,354	8,979	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	50,463	1,021,903	0.049381	0	0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	611,684	2,614,378	0.233969	0	0	88.01
91.00	09100	EMERGENCY	563,494	4,965,605	0.113479	819	93	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	146,594	230,195	0.636825	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,404,662	43,749,348		825,489	27,170	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/21/2014 1:14 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	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	0	0	0	0	88.01
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/21/2014 1:14 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	5,783,897	0.000000	0.000000	31,967	50.00
53.00	05300	ANESTHESIOLOGY	0	646,809	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,620,800	0.000000	0.000000	41,943	54.00
56.00	03630	ULTRA SOUND	0	952,541	0.000000	0.000000	26,894	56.00
60.00	06000	LABORATORY	0	11,343,065	0.000000	0.000000	205,853	60.00
66.00	06600	PHYSICAL THERAPY	0	3,443,554	0.000000	0.000000	35,902	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	294,484	0.000000	0.000000	5,021	67.00
68.00	06800	SPEECH PATHOLOGY	0	69,352	0.000000	0.000000	7,000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	429,569	0.000000	0.000000	5,386	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,258,878	0.000000	0.000000	136,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	139,286	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,935,032	0.000000	0.000000	328,354	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	1,021,903	0.000000	0.000000	0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	2,614,378	0.000000	0.000000	0	88.01
91.00	09100	EMERGENCY	0	4,965,605	0.000000	0.000000	819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	230,195	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	43,749,348			825,489	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/21/2014 1:14 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	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	03630	ULTRA SOUND	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	0	0		88.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 1:14 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	0.403176	0	1,228,198	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.324173	0	124,891	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.366692	0	1,773,347	0	0	54.00
56.00	03630	ULTRA SOUND	0.114384	0	220,090	0	0	56.00
60.00	06000	LABORATORY	0.215420	0	3,145,839	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.384627	0	959,147	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.992553	0	54,628	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.318246	0	1,987	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.037687	0	126,538	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.178746	0	280,170	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.260443	0	14,270	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226879	0	1,677,589	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0.000000				0	88.01
91.00	09100	EMERGENCY	0.683679	0	1,267,376	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.219596	0	91,952	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.422171		0			95.00
200.00		Subtotal (see instructions)		0	10,966,022	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	10,966,022	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/21/2014 1:14 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	495,180	0		50.00
53.00	05300	ANESTHESIOLOGY	40,486	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	650,272	0		54.00
56.00	03630	ULTRA SOUND	25,175	0		56.00
60.00	06000	LABORATORY	677,677	0		60.00
66.00	06600	PHYSICAL THERAPY	368,914	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	54,221	0		67.00
68.00	06800	SPEECH PATHOLOGY	632	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,769	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,079	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,717	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	380,610	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	0		88.01
91.00	09100	EMERGENCY	866,478	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	112,144	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	3,730,354	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,730,354	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141301 | Component CCN: 14Z301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/21/2014 1:14 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	0.403176	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.324173	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.366692	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0.114384	0	0	0	0	56.00
60.00	06000	LABORATORY	0.215420	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.384627	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.992553	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.318246	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.037687	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.178746	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.260443	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226879	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0.000000				0	88.01
91.00	09100	EMERGENCY	0.683679	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.219596	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.422171		0			95.00
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: 141301 | Component CCN: 14Z301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/21/2014 1:14 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
56.00	03630	ULTRA SOUND	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 1:14 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)	1,788	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	778	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)	669	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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)	778	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	232	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	382	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)	0	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)	503	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	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,038,898	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	31,213	25.00
26.00	Total swing-bed cost (see instructions)	2,035,053	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,003,845	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,003,845	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)	2,575.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	983,891	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)	983,891	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 1:14 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)	196,342	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,180,233	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,295,542	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,295,542	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)	109	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,575.64	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	280,745	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/21/2014 1:14 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	1,046,329	2,003,845	0.522161	280,745	146,594	90.00
91.00	Nursing School cost	0	2,003,845	0.000000	280,745	0	91.00
92.00	Allied health cost	0	2,003,845	0.000000	280,745	0	92.00
93.00	All other Medical Education	0	2,003,845	0.000000	280,745	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 1:14 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		799,426		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.403176	31,967	12,888	50.00
53.00	05300	ANESTHESIOLOGY	0.324173	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.366692	41,943	15,380	54.00
56.00	03630	ULTRA SOUND	0.114384	26,894	3,076	56.00
60.00	06000	LABORATORY	0.215420	205,853	44,345	60.00
66.00	06600	PHYSICAL THERAPY	0.384627	35,902	13,809	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.992553	5,021	4,984	67.00
68.00	06800	SPEECH PATHOLOGY	0.318246	7,000	2,228	68.00
69.00	06900	ELECTROCARDIOLOGY	0.037687	5,386	203	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.178746	136,350	24,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.260443	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226879	328,354	74,497	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0.000000		0	88.01
91.00	09100	EMERGENCY	0.683679	819	560	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.219596	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		825,489	196,342	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)		825,489		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141301 | Component CCN: 14Z301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/21/2014 1:14 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	0.403176	13,950	5,624	50.00
53.00	05300	ANESTHESIOLOGY	0.324173	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.366692	30,672	11,247	54.00
56.00	03630	ULTRA SOUND	0.114384	12,498	1,430	56.00
60.00	06000	LABORATORY	0.215420	107,995	23,264	60.00
66.00	06600	PHYSICAL THERAPY	0.384627	115,355	44,369	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.992553	81,485	80,878	67.00
68.00	06800	SPEECH PATHOLOGY	0.318246	8,262	2,629	68.00
69.00	06900	ELECTROCARDIOLOGY	0.037687	570	21	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.178746	59,032	10,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.260443	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.226879	273,720	62,101	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RHC #1 ATWOOD RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RHC #2 KIRBY MEDICAL GROUP RHC	0.000000		0	88.01
91.00	09100	EMERGENCY	0.683679	410	280	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.219596	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		703,949	242,395	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)		703,949		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141301	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/21/2014 1:14 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,730,354	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)	3,730,354	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)	3,767,658	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	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)	15,840	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,554,929	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)	2,196,889	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)	2,196,889	30.00
31.00	Primary payer payments	10,543	31.00
32.00	Subtotal (line 30 minus line 31)	2,186,346	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)	205,500	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	180,840	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	153,636	36.00
37.00	Subtotal (see instructions)	2,367,186	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	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,367,186	40.00
40.01	Sequestration adjustment (see instructions)	47,344	40.01
41.00	Interim payments	4,289,722	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-1,969,880	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2014 1:14 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,225,104		4,695,722	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	02/19/2014	315,800	02/19/2014	406,000	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)		-315,800		-406,000	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)		909,304		4,289,722	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		161,204		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,969,880	6.02
7.00	Total Medicare program liability (see instructions)		1,070,508		2,319,842	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2014 1:14 pm

Component CCN: 14Z301 | 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		1,614,646		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	02/19/2014	340,200		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)		-340,200		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)		1,274,446		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		241,645		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,516,091		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141301	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 11/21/2014 1:14 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	223	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	382	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	128	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	669	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	48,766,890	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	1,480,933	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	94,948	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	93,638	8.00
9.00	Sequestration adjustment amount (see instructions)	1,873	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	91,765	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	91,765	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141301 | Component CCN: 14Z301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-2 | Date/Time Prepared: 11/21/2014 1:14 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)	1,308,497	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 6 and 7, line 202 for Part B) (For CAH, see instructions)	244,819	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	503	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)	1,553,316	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,553,316	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)	1,553,316	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,284	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)	1,547,032	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,547,032	0	19.00
19.01	Sequestration adjustment (see instructions)	30,941	0	19.01
20.00	Interim payments	1,274,446	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	241,645	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141301	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/21/2014 1:14 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,180,233	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,180,233	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,192,035	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 physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,192,035	19.00
20.00	Deductibles (exclude professional component)	102,756	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,089,279	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,089,279	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,496	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,076	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,092,355	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,092,355	30.00
30.01	Sequestration adjustment (see instructions)	21,847	30.01
31.00	Interim payments	909,304	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	161,204	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/21/2014 1:14 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	3,026,927	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	12,146,200	0	0	0	4.00
5.00	Other receivable	381,328	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,128,331	0	0	0	6.00
7.00	Inventory	230,497	0	0	0	7.00
8.00	Prepaid expenses	643,740	0	0	0	8.00
9.00	Other current assets	-288,474	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,011,887	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	349,650	0	0	0	12.00
13.00	Land improvements	4,856,567	0	0	0	13.00
14.00	Accumulated depreciation	-769,871	0	0	0	14.00
15.00	Buildings	15,743,095	0	0	0	15.00
16.00	Accumulated depreciation	-2,525,819	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	10,003,358	0	0	0	19.00
20.00	Accumulated depreciation	-1,789,468	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	5,615,117	0	0	0	23.00
24.00	Accumulated depreciation	-2,765,713	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	2,888,173	0	0	0	27.00
28.00	Accumulated depreciation	-1,778,411	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	29,826,678	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	32,855,062	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)	32,855,062	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,693,627	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,253,904	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,595,463	0	0	0	38.00
39.00	Payroll taxes payable	46,535	0	0	0	39.00
40.00	Notes and loans payable (short term)	861,536	0	0	0	40.00
41.00	Deferred income	28,730	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	569,523	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,355,691	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	28,152,750	0	0	0	46.00
47.00	Notes payable	313,657	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	28,466,407	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	32,822,098	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	38,871,529				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)	38,871,529	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,693,627	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/21/2014 1:14 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		35,407,135		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,464,395				2.00
3.00	Total (sum of line 1 and line 2)		38,871,530		0		3.00
4.00		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)		38,871,530		0		11.00
12.00	ROUNDING	1		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)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		38,871,529		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			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	ROUNDING		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: 141301 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/21/2014 1:14 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,978,669		2,978,669	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,978,669		2,978,669	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)	2,978,669		2,978,669	17.00
18.00	Ancillary services	2,822,406	32,094,861	34,917,267	18.00
19.00	Outpatient services	1,230	5,194,570	5,195,800	19.00
20.00	RHC #1 ATWOOD RURAL HEALTH CLINIC	0	1,021,903	1,021,903	20.00
20.01	RHC #2 KIRBY MEDICAL GROUP RHC	0	2,614,378	2,614,378	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,038,873	2,038,873	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	158,898	2,832,580	2,991,478	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,961,203	45,797,165	51,758,368	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,273,521		29.00
30.00	JEFFERSON PARKWAY	20,393			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)		20,393		36.00
37.00		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)		26,293,914		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141301	Period: From 07/01/2013 To 06/30/2014	Worksheet G-3 Date/Time Prepared: 11/21/2014 1:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,758,368	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,678,503	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,079,865	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,293,914	4.00
5.00	Net income from service to patients (line 3 minus line 4)	785,951	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,193,544	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	123,830	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	0	17.00
18.00	Revenue from sale of medical records and abstracts	397	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	15,801	22.00
23.00	Governmental appropriations	57,460	23.00
24.00	GRANT REVENUE	803,908	24.00
24.01	MISCELLANEOUS REVENUE	483,504	24.01
25.00	Total other income (sum of lines 6-24)	2,678,444	25.00
26.00	Total (line 5 plus line 25)	3,464,395	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)	3,464,395	29.00

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

Provider CCN: 141301 Component CCN: 143438 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/21/2014 1:14 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	42,397	0	42,397	0	42,397	1.00
2.00	Physician Assistant	117,390	0	117,390	0	117,390	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	119,988	0	119,988	0	119,988	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)	279,775	0	279,775	0	279,775	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	60,626	60,626	0	60,626	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	605	605	0	605	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	61,231	61,231	0	61,231	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	279,775	61,231	341,006	0	341,006	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	12,959	12,959	0	12,959	29.00
30.00	Administrative Costs	68,785	116,262	185,047	-29,823	155,224	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	68,785	129,221	198,006	-29,823	168,183	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	348,560	190,452	539,012	-29,823	509,189	32.00

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

Provider CCN: 141301 | Component CCN: 143438 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/21/2014 1:14 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	42,397		1.00
2.00	Physician Assistant	0	117,390		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	119,988		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	279,775		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	60,626		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	605		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	61,231		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	341,006		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	12,959		29.00
30.00	Administrative Costs	0	155,224		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	168,183		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	509,189		32.00

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

Provider CCN: 141301 Component CCN: 143495 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/21/2014 1:14 pm

Rural Health Clinic (RHC) II | 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	539,609	0	539,609	-25,415	514,194	1.00
2.00	Physician Assistant	170,049	0	170,049	0	170,049	2.00
3.00	Nurse Practitioner	32,032	0	32,032	0	32,032	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	347,528	0	347,528	0	347,528	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)	1,089,218	0	1,089,218	-25,415	1,063,803	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	292,321	292,321	0	292,321	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	292,321	292,321	0	292,321	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,089,218	292,321	1,381,539	-25,415	1,356,124	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	21,792	21,792	0	21,792	29.00
30.00	Administrative Costs	349,872	509,164	859,036	-124,522	734,514	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	349,872	530,956	880,828	-124,522	756,306	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,439,090	823,277	2,262,367	-149,937	2,112,430	32.00

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

Provider CCN: 141301 Component CCN: 143495 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/21/2014 1:14 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	514,194		1.00
2.00	Physician Assistant	0	170,049		2.00
3.00	Nurse Practitioner	0	32,032		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	347,528		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	1,063,803		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	292,321		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	292,321		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,356,124		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	21,792		29.00
30.00	Administrative Costs	0	734,514		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	756,306		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,112,430		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141301 Component CCN: 143438

Period: From 07/01/2013 To 06/30/2014

Worksheet M-2

Date/Time Prepared: 11/21/2014 1:14 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	0.26	656	4,200	1,092		1.00
2.00	Physician Assistant	0.91	4,409	2,100	1,911		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	1.17	5,065		3,003	5,065	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)	1.17	5,065			5,065	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)					341,006	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)					341,006	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)					168,183	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					217,419	15.00
16.00	Total overhead (sum of lines 14 and 15)					385,602	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					385,602	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					385,602	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					726,608	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141301 | Component CCN: 143495 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-2 | Date/Time Prepared: 11/21/2014 1:14 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.35	8,282	4,200	9,870		1.00
2.00	Physician Assistant	1.46	4,120	2,100	3,066		2.00
3.00	Nurse Practitioner	0.27	693	2,100	567		3.00
4.00	Subtotal (sum of lines 1-3)	4.08	13,095		13,503	13,503	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	0.21	576			576	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	4.29	13,671			14,079	8.00
9.00	Physician Services Under Agreements		765			765	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)					1,356,124	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)					1,356,124	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)					756,306	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,644,502	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,400,808	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					2,400,808	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,400,808	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					3,756,932	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141301 Component CCN: 143438	Period: From 07/01/2013 To 06/30/2014	Worksheet M-3 Date/Time Prepared: 11/21/2014 1:14 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)		726,608	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		25,459	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		701,149	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,065	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)		5,065	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		138.43	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. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	138.43	138.43	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	578	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	80,013	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) *		80,013	16.00
16.01	Total program charges (see instructions)(from contractor's records)		120,094	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,057	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		704	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.)		55,456	16.04
16.05	Total program cost (see instructions)		56,160	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,989	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		21,810	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		56,160	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,312	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		61,472	22.00
23.00	Allowable bad debts (see instructions)		3,784	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		3,330	23.01
24.00	Allowable 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 (see instructions)		64,802	26.00
26.01	Sequestration adjustment (see instructions)		1,296	26.01
27.00	Interim payments		55,783	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		7,723	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141301 Component CCN: 143495	Period: From 07/01/2013 To 06/30/2014	Worksheet M-3 Date/Time Prepared: 11/21/2014 1:14 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		3,756,932	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		67,095	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,689,837	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		14,079	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		765	5.00
6.00	Total adjusted visits (line 4 plus line 5)		14,844	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		248.57	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. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	248.57	248.57	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,589	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	643,548	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) *		643,548	16.00
16.01	Total program charges (see instructions)(from contractor's records)		468,499	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		20,480	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		28,132	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.)		455,147	16.04
16.05	Total program cost (see instructions)		483,279	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		46,482	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		80,308	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		483,279	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		22,547	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		505,826	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		505,826	26.00
26.01	Sequestration adjustment (see instructions)		10,117	26.01
27.00	Interim payments		469,895	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		25,814	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: 141301 | Component CCN: 143438 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-4 | Date/Time Prepared: 11/21/2014 1:14 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)	279,775	279,775	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003287	0.019310	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	920	5,402	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,772	2,854	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,692	8,256	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	341,006	341,006	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	385,602	385,602	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.010827	0.024211	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	4,175	9,336	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	7,867	17,592	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	48	282	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	163.90	62.38	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	13	51	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,131	3,181	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)		25,459	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		5,312	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141301 | Component CCN: 143495 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-4 | Date/Time Prepared: 11/21/2014 1:14 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	1,063,803	1,063,803	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001725	0.010957	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,835	11,656	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,081	5,647	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,916	17,303	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,356,124	1,356,124	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	2,400,808	2,400,808	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005100	0.012759	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	12,244	30,632	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	19,160	47,935	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	88	558	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	217.73	85.91	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	42	156	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,145	13,402	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)		67,095	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)		22,547	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141301 Component CCN: 143438	Period: From 07/01/2013 To 06/30/2014	Worksheet M-5 Date/Time Prepared: 11/21/2014 1:14 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		55,783	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		55,783	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		7,723	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		63,506	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141301 Component CCN: 143495	Period: From 07/01/2013 To 06/30/2014	Worksheet M-5 Date/Time Prepared: 11/21/2014 1:14 pm
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		469,895	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		469,895	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		25,814	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		495,709	7.00

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