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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1300	PERIOD FROM 9/ 1/2009 TO 8/31/2010	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 2/14/2011 TIME 11:26

PART I - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
THOMAS H BOYD CRITICAL ACC HOSPITAL 14-1300
FOR THE COST REPORTING PERIOD BEGINNING 9/ 1/2009 AND ENDING 8/31/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

_____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX
			A	B	
		1	2	3	4
1	HOSPITAL	0	-64,181	-299,534	0
3	SWING BED - SNF	0	-130,657	0	0
9	RHC	0	0	2,731	0
9 .01	RHC II	0	0	3,773	0
9 .02	RHC III	0	0	6,775	0
9 .03	RHC IV	0	0	35,784	0
100	TOTAL	0	-194,838	-250,471	0

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 ADDRESS

1 STREET: 800 SCHOOL STREET P.O. BOX:
1.01 CITY: CARROLLTON STATE: IL ZIP CODE: 62016- COUNTY: GREENE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
0	1	2	2.01	3	4	5	6
02.00 HOSPITAL	THOMAS H BOYD CRITICAL ACC HOSPITAL	14-1300		7/12/1999	N	O	O
04.00 SWING BED - SNF	THOMAS H BOYD CRITICAL ACC SWING BED	14-Z300		7/12/1999	N	O	N
14.00 HOSPITAL-BASED RHC	GREENE COUNTY RHC	14-3403		6/22/1995	N	O	N
14.01 HOSPITAL-BASED RHC 2	T.H. BOYD RHC	14-3475		10/ 2/2005	N	O	N
14.02 HOSPITAL-BASED RHC 3	BOYD-FILLAGER GREENFIELD RHC	14-3474		10/ 3/2005	N	O	N
14.03 HOSPITAL-BASED RHC 4	RHC OF ROODHOUSE	14-3476		10/ 4/2005	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 9/ 1/2009 TO: 8/31/2010

		1	2
18	TYPE OF CONTROL	2	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1
20	SUBPROVIDER	

OTHER INFORMATION

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

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N			
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?				
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.				
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	N			
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	N	N		
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	N	N		
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0			
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /				
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /				
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	7/12/1999		
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02				
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	1	2	3	4
		0	0.0000	0.0000	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0		
	A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)	%	Y/N		
28.03	STAFFING	0.00%			
28.04	RECRUITMENT	0.00%			
28.05	RETENTION	0.00%			
28.06	TRAINING	0.00%			
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N			
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y			
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N			
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N			
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N			
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N			
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			

MISCELLANEOUS COST REPORT INFORMATION

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

		V	XVIII	XIX
	PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	1	2	3
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?			

	TITLE XIX INPATIENT SERVICES	
38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	Y
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	N
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	N
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	Y
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	N

40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).	N	
40.01	NAME: FI/CONTRACTOR NAME		FI/CONTRACTOR #
40.02	STREET: P.O. BOX:		
40.03	CITY: STATE: ZIP CODE: -		
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	Y	
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N	
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).		

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

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

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N	
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N	
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /		
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		
	PREMIUMS:	184,382	
	PAID LOSSES:	0	
	AND/OR SELF INSURANCE:	0	
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

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

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

MULTICAMPUS

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

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

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

SETTLEMENT DATA

63.00	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY).	Y	11/10/2010

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	I/P DAYS / TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS / TOTAL TITLE XIX
		1	2	2.01	3	4	4.01	5
1	ADULTS & PEDIATRICS	18	6,570	20,448.00		652		33
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					902		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	18	6,570	20,448.00		1,554		33
12	TOTAL	18	6,570	20,448.00		1,554		33
13	RPCH VISITS							
14	SUBPROVIDER							
16	NURSING FACILITY							
20	AMBULATORY SURGICAL CENTER (							
24	RURAL HEALTH CLINIC					253		359
24 01	RURAL HEALTH CLINIC 2					522		1,124
24 02	RURAL HEALTH CLINIC 3					1,045		146
24 03	RURAL HEALTH CLINIC 4					635		261
25	TOTAL	18						
26	OBSERVATION BED DAYS							30
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL OBSERVATION BEDS ADMITTED	TRIPS / TOTAL OBSERVATION BEDS NOT ADMITTED	-- INTERNS & RES. FTES -- TOTAL	LESS I&R REPL NON-PHYS ANES
		5.01	5.02	6	6.01	6.02	7	8
1	ADULTS & PEDIATRICS			881				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			958				
4	ADULTS & PED-SB NF			1,554				
5	TOTAL ADULTS AND PEDS			3,393				
12	TOTAL			3,393				
13	RPCH VISITS							
14	SUBPROVIDER							
16	NURSING FACILITY							
20	AMBULATORY SURGICAL CENTER (							
24	RURAL HEALTH CLINIC			1,720				
24 01	RURAL HEALTH CLINIC 2			5,993				
24 02	RURAL HEALTH CLINIC 3			3,415				
24 03	RURAL HEALTH CLINIC 4			1,876				
25	TOTAL							
26	OBSERVATION BED DAYS	7	23	309	74	235		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES NET	FULL TIME EQUIV EMPLOYEES ON PAYROLL	FULL TIME EQUIV NONPAID WORKERS	DISCHARGES TITLE V	DISCHARGES TITLE XVIII	DISCHARGES TITLE XIX	TOTAL ALL PATIENTS
		9	10	11	12	13	14	15
1	ADULTS & PEDIATRICS					240	20	337
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		113.86			240	20	337
13	RPCH VISITS							
14	SUBPROVIDER							
16	NURSING FACILITY							
20	AMBULATORY SURGICAL CENTER (							
24	RURAL HEALTH CLINIC		3.12					
24 01	RURAL HEALTH CLINIC 2		9.17					
24 02	RURAL HEALTH CLINIC 3		4.13					
24 03	RURAL HEALTH CLINIC 4		2.21					
25	TOTAL		132.49					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	PROVIDER NO: 14-1300	PERIOD: FROM 9/ 1/2009 TO 8/31/2010	PREPARED 2/14/2011 WORKSHEET S-8
	COMPONENT NO: 14-3403		

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 505 S MAIN

1.01 CITY: WHITE HALL STATE: IL ZIP CODE: 62092 COUNTY: GREENE

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

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

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

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

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

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM	SUNDAY TO	MONDAY FROM	MONDAY TO	TUESDAY FROM	TUESDAY TO	WEDNESDAY FROM	WEDNESDAY TO	THURSDAY FROM	THURSDAY TO	FRIDAY FROM	FRIDAY TO	SATURDAY FROM	SATURDAY TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC			800	1700	800	1700	800	1700	800	1700	800	1200		

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

PROVIDER NO:	PERIOD:	PREPARED 2/14/2011
14-1300	FROM 9/ 1/2009	WORKSHEET S-8
COMPONENT NO:	TO 8/31/2010	
14-3475		

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

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 800 SCHOOL STREET

1.01 CITY: CARROLLTON STATE: IL ZIP CODE: 62016 COUNTY: GREENE

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

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

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

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

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

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14
	0														
12	CLINIC	700	2100	700	2100	700	2100	700	2100	700	2100	700	2100	700	2100

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	PROVIDER NO: 14-1300	PERIOD: FROM 9/ 1/2009 TO 8/31/2010	PREPARED 2/14/2011
	COMPONENT NO: 14-3474		WORKSHEET S-8

RHC 3

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 712 COLLEGE ST

1.01 CITY: GREENFIELD STATE: IL ZIP CODE: 62044 COUNTY: GREENE

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

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

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NUMBER
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		
		PHYSICIAN NAME	HOURS OF SUPERVISION
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		

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

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM	SUNDAY TO	MONDAY FROM	MONDAY TO	TUESDAY FROM	TUESDAY TO	WEDNESDAY FROM	WEDNESDAY TO	THURSDAY FROM	THURSDAY TO	FRIDAY FROM	FRIDAY TO	SATURDAY FROM	SATURDAY TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC			800	1700	800	1700	800	1700	800	1700	800	1700		

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	PROVIDER NO: 14-1300	PERIOD: FROM 9/ 1/2009 TO 8/31/2010	PREPARED 2/14/2011
	COMPONENT NO: 14-3476		WORKSHEET S-8

RHC 4

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 132 W LORTON

1.01 CITY: ROODHOUSE STATE: IL ZIP CODE: 62082 COUNTY: GREENE

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

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

PHYSICIAN INFORMATION:

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

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

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14
12 CLINIC			800	1700	800	1700	800	1700	800	1700	800	1700		

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
1	0100	OLD CAP REL COSTS-BLDG & FIXT					
2	0200	OLD CAP REL COSTS-MVBLE EQUIP					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		164,402	164,402	-81,937	82,465
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				406,669	406,669
5	0500	EMPLOYEE BENEFITS		422,785	422,785	125,648	548,433
6	0600	ADMINISTRATIVE & GENERAL	632,802	646,744	1,279,546	-5,298	1,274,248
8	0800	OPERATION OF PLANT	51,879	171,239	223,118	10,782	233,900
9	0900	LAUNDRY & LINEN SERVICE	24,500	8,106	32,606		32,606
10	1000	HOUSEKEEPING	60,525	32,297	92,822	7,123	99,945
11	1100	DIETARY	143,276	76,269	219,545		219,545
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	35,944	4,594	40,538	97,881	138,419
15	1500	CENTRAL SERVICES & SUPPLY					
16	1600	PHARMACY					
17	1700	MEDICAL RECORDS & LIBRARY	140,053	17,221	157,274		157,274
24	2400	PARAMED ED PRGM					
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,157,240	185,423	1,342,663	-28,629	1,314,034
31	3100	SUBPROVIDER					
35	3500	NURSING FACILITY					
		ANCILLARY SRVC COST CNTRS					
41	4100	RADIOLOGY-DIAGNOSTIC	336,300	385,887	722,187	-194,820	527,367
44	4400	LABORATORY	231,997	330,090	562,087	-50,303	511,784
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	4700	BLOOD STORING, PROCESSING & TRANS.		15,405	15,405	2,013	17,418
48	4800	INTRAVENOUS THERAPY					
50	5000	PHYSICAL THERAPY	135,845	29,056	164,901		164,901
53	5300	ELECTROCARDIOLOGY		29,383	29,383	13,420	42,803
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,049	72,175	91,224		91,224
55.30	5530	IMPL. DEV. CHARGED TO PATIENT					
56	5600	DRUGS CHARGED TO PATIENTS		312,218	312,218		312,218
59	3950	OTHER ANCILLARY SERVICE COST CENTERS					
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	6,820	487	7,307		7,307
61	6100	EMERGENCY	845,501	380,314	1,225,815	-39,546	1,186,269
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC	133,870	38,469	172,339	-36,411	135,928
63.51	6311	RURAL HEALTH CLINIC 2	383,173	34,860	418,033	-74,808	343,225
63.52	6312	RURAL HEALTH CLINIC 3	269,603	40,954	310,557	-48,477	262,080
63.53	6313	RURAL HEALTH CLINIC 4	176,500	44,374	220,874	-5,701	215,173
		OTHER REIMBURS COST CNTRS					
65	6500	AMBULANCE SERVICES	426,213	119,722	545,935		545,935
68	5950	OTHER REIMBURSABLE COST CENTERS					
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		68,871	68,871	-68,871	
89	8900	UTILIZATION REVIEW-SNF					
90	9000	OTHER CAPITAL RELATED COSTS		28,735	28,735	-28,735	
92	9200	AMBULATORY SURGICAL CENTER (D.P.)					
94	6950	OTHER SPECIAL PURPOSE (SPECIFY)					
95		SUBTOTALS	5,211,090	3,660,080	8,871,170	-0-	8,871,170
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
97	9700	RESEARCH					
98	9800	PHYSICIANS' PRIVATE OFFICES	44,070	1,475	45,545		45,545
98.01	9801	JAIL MEALS					
98.02	9802	OUTPATIENT MEALS					
98.03	9803	IDLE SPACE					
99	9900	NONPAID WORKERS					
100	7950	OTHER NONREIMBURSABLE COST CENTERS					
101		TOTAL	5,255,160	3,661,555	8,916,715	-0-	8,916,715

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
1	0100	OLD CAP REL COSTS-BLDG & FIXT		
2	0200	OLD CAP REL COSTS-MVBLE EQUIP		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	-5,757	76,708
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	-1,904	404,765
5	0500	EMPLOYEE BENEFITS	4,286	552,719
6	0600	ADMINISTRATIVE & GENERAL	-53,479	1,220,769
8	0800	OPERATION OF PLANT		233,900
9	0900	LAUNDRY & LINEN SERVICE		32,606
10	1000	HOUSEKEEPING		99,945
11	1100	DIETARY	-36,382	183,163
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION		138,419
15	1500	CENTRAL SERVICES & SUPPLY		
16	1600	PHARMACY		
17	1700	MEDICAL RECORDS & LIBRARY	-3,718	153,556
24	2400	PARAMED ED PRGM		
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		1,314,034
31	3100	SUBPROVIDER		
35	3500	NURSING FACILITY		
		ANCILLARY SRVC COST CNTRS		
41	4100	RADIOLOGY-DIAGNOSTIC	-335	527,032
44	4400	LABORATORY	-100	511,684
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		
47	4700	BLOOD STORING, PROCESSING & TRANS.		17,418
48	4800	INTRAVENOUS THERAPY		
50	5000	PHYSICAL THERAPY		164,901
53	5300	ELECTROCARDIOLOGY		42,803
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-65	91,159
55.30	5530	IMPL. DEV. CHARGED TO PATIENT		
56	5600	DRUGS CHARGED TO PATIENTS		312,218
59	3950	OTHER ANCILLARY SERVICE COST CENTERS		
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC		7,307
61	6100	EMERGENCY	-104,028	1,082,241
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310	RURAL HEALTH CLINIC		135,928
63.51	6311	RURAL HEALTH CLINIC 2		343,225
63.52	6312	RURAL HEALTH CLINIC 3		262,080
63.53	6313	RURAL HEALTH CLINIC 4		215,173
		OTHER REIMBURS COST CNTRS		
65	6500	AMBULANCE SERVICES	-452	545,483
68	5950	OTHER REIMBURSABLE COST CENTERS		
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
89	8900	UTILIZATION REVIEW-SNF		-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
92	9200	AMBULATORY SURGICAL CENTER (D.P.)		
94	6950	OTHER SPECIAL PURPOSE (SPECIFY)		
95		SUBTOTALS	-201,934	8,669,236
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
97	9700	RESEARCH		
98	9800	PHYSICIANS' PRIVATE OFFICES		45,545
98.01	9801	JAIL MEALS		
98.02	9802	OUTPATIENT MEALS		
98.03	9803	IDLE SPACE		
99	9900	NONPAID WORKERS		
100	7950	OTHER NONREIMBURSABLE COST CENTERS		
101		TOTAL	-201,934	8,714,781

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 2/14/2011
I 14-1300 I FROM 9/ 1/2009 I NOT A CMS WORKSHEET
I I TO 8/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
1	OLD CAP REL COSTS-BLDG & FIXT	0100	
2	OLD CAP REL COSTS-MVBLE EQUIP	0200	
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
24	PARAMED ED PRGM	2400	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
31	SUBPROVIDER	3100	
35	NURSING FACILITY	3500	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
47	BLOOD STORING, PROCESSING & TRANS.	4700	
48	INTRAVENOUS THERAPY	4800	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.30	IMPL. DEV. CHARGED TO PATIENT	5530	IMPL. DEV. CHARGED TO PATIENT
56	DRUGS CHARGED TO PATIENTS	5600	
59	OTHER ANCILLARY SERVICE COST CENTERS	3950	OTHER ANCILLARY SERVICE COST CENTERS
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
63.51	RURAL HEALTH CLINIC 2	6311	RURAL HEALTH CLINIC #####
63.52	RURAL HEALTH CLINIC 3	6312	RURAL HEALTH CLINIC #####
63.53	RURAL HEALTH CLINIC 4	6313	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
68	OTHER REIMBURSABLE COST CENTERS	5950	OTHER REIMBURSABLE COST CENTERS
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
89	UTILIZATION REVIEW-SNF	8900	
90	OTHER CAPITAL RELATED COSTS	9000	
92	AMBULATORY SURGICAL CENTER (D.P.)	9200	
94	OTHER SPECIAL PURPOSE (SPECIFY)	6950	OTHER SPECIAL PURPOSE (SPECIFY)
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	JAIL MEALS	9801	PHYSICIANS' PRIVATE OFFICES
98.02	OUTPATIENT MEALS	9802	PHYSICIANS' PRIVATE OFFICES
98.03	IDLE SPACE	9803	PHYSICIANS' PRIVATE OFFICES
99	NONPAID WORKERS	9900	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	INCREASE SALARY	INCREASE OTHER
		1	2	3	4	5
1	RECLASS EQUIPMENT DEPRECIATION	A	NEW CAP REL COSTS-MVBLE EQUIP	4		102,384
2	RECLASS INTEREST EXPENSE	B	ADMINISTRATIVE & GENERAL	6		51,975
3			NEW CAP REL COSTS-MVBLE EQUIP	4		16,896
4	RECLASS SALARIES TO EKG COST CENTER	C	ELECTROCARDIOLOGY	53	12,466	954
5						
6	RECLASSIFY INSURANCE EXPENSES	D	EMPLOYEE BENEFITS	5		125,648
7			OTHER CAPITAL RELATED COSTS	90		636
8			RURAL HEALTH CLINIC	63.50		2,269
9			RURAL HEALTH CLINIC 2	63.51		7,075
10			RURAL HEALTH CLINIC 3	63.52		18,278
11			RURAL HEALTH CLINIC 4	63.53		31,926
12	NURSING ADMIN WAGES & BENEFITS	E	NURSING ADMINISTRATION	14	91,842	6,039
13	RECLASSIFY RHC ADMIN COSTS	F	ADMINISTRATIVE & GENERAL	6		21,183
14			OPERATION OF PLANT	8		22,962
15						
16						
17	ADMIN & HOUSEKEEPING TIME - CLINICS	G	ADMINISTRATIVE & GENERAL	6	150,597	15,114
18			HOUSEKEEPING	10	6,052	1,071
19						
20						
21	LAB TIME	H	LABORATORY	44	6,751	1,215
22						
23						
24			BLOOD STORING, PROCESSING & TRANS.	47	1,880	133
25	RECLASSIFY ER ADMIN TIME	I	ADMINISTRATIVE & GENERAL	6	23,977	15,569
26	RECLASSIFY LEASES TO CAPITAL	J	NEW CAP REL COSTS-MVBLE EQUIP	4		278,465
27						
28						
29						
36	TOTAL RECLASSIFICATIONS				293,565	719,792

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

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	DECREASE SALARY	DECREASE OTHER	A-7 REF
		1	6	7	8	9	10
1	RECLASS EQUIPMENT DEPRECIATION	A	NEW CAP REL COSTS-BLDG & FIXT	3		102,384	9
2	RECLASS INTEREST EXPENSE	B	INTEREST EXPENSE	88		68,871	
3							11
4	RECLASS SALARIES TO EKG COST CENTER	C	RADIOLOGY-DIAGNOSTIC	41	5,976	457	
5			ADULTS & PEDIATRICS	25	6,490	497	
6	RECLASSIFY INSURANCE EXPENSES	D	ADMINISTRATIVE & GENERAL	6		185,832	
7							
8							
9							
10							
11							
12	NURSING ADMIN WAGES & BENEFITS	E	ADMINISTRATIVE & GENERAL	6	91,842	6,039	
13	RECLASSIFY RHC ADMIN COSTS	F	RURAL HEALTH CLINIC	63.50		11,614	
14			RURAL HEALTH CLINIC 2	63.51		14,243	
15			RURAL HEALTH CLINIC 3	63.52		8,829	
16			RURAL HEALTH CLINIC 4	63.53		9,459	
17	ADMIN & HOUSEKEEPING TIME - CLINICS	G	RURAL HEALTH CLINIC	63.50	24,180	1,990	
18			RURAL HEALTH CLINIC 2	63.51	64,564	3,076	
19			RURAL HEALTH CLINIC 3	63.52	48,540	6,198	
20			RURAL HEALTH CLINIC 4	63.53	19,365	4,921	
21	LAB TIME	H	RURAL HEALTH CLINIC	63.50	827	69	
22			RURAL HEALTH CLINIC 3	63.52	2,828	360	
23			RURAL HEALTH CLINIC 4	63.53	3,096	786	
24			LABORATORY	44	1,880	133	
25	RECLASSIFY ER ADMIN TIME	I	EMERGENCY	61	23,977	15,569	
26	RECLASSIFY LEASES TO CAPITAL	J	OPERATION OF PLANT	8		12,180	10
27			ADULTS & PEDIATRICS	25		21,642	10
28			RADIOLOGY-DIAGNOSTIC	41		188,387	10
29			LABORATORY	44		56,256	10
36	TOTAL RECLASSIFICATIONS				293,565	719,792	

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

RECLASS CODE: A
EXPLANATION : RECLASS EQUIPMENT DEPRECIATION

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	102,384	NEW CAP REL COSTS-BLDG & FIXT	3	102,384
TOTAL RECLASSIFICATIONS FOR CODE A			102,384			102,384

RECLASS CODE: B
EXPLANATION : RECLASS INTEREST EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	51,975	INTEREST EXPENSE	88	68,871
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	16,896			0
TOTAL RECLASSIFICATIONS FOR CODE B			68,871			68,871

RECLASS CODE: C
EXPLANATION : RECLASS SALARIES TO EKG COST CENTER

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	13,420	RADIOLOGY-DIAGNOSTIC	41	6,433
2.00			0	ADULTS & PEDIATRICS	25	6,987
TOTAL RECLASSIFICATIONS FOR CODE C			13,420			13,420

RECLASS CODE: D
EXPLANATION : RECLASSIFY INSURANCE EXPENSES

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	EMPLOYEE BENEFITS	5	125,648	ADMINISTRATIVE & GENERAL	6	185,832
2.00	OTHER CAPITAL RELATED COSTS	90	636			0
3.00	RURAL HEALTH CLINIC	63.50	2,269			0
4.00	RURAL HEALTH CLINIC 2	63.51	7,075			0
5.00	RURAL HEALTH CLINIC 3	63.52	18,278			0
6.00	RURAL HEALTH CLINIC 4	63.53	31,926			0
TOTAL RECLASSIFICATIONS FOR CODE D			185,832			185,832

RECLASS CODE: E
EXPLANATION : NURSING ADMIN WAGES & BENEFITS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NURSING ADMINISTRATION	14	97,881	ADMINISTRATIVE & GENERAL	6	97,881
TOTAL RECLASSIFICATIONS FOR CODE E			97,881			97,881

RECLASS CODE: F
EXPLANATION : RECLASSIFY RHC ADMIN COSTS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	21,183	RURAL HEALTH CLINIC	63.50	11,614
2.00	OPERATION OF PLANT	8	22,962	RURAL HEALTH CLINIC 2	63.51	14,243
3.00			0	RURAL HEALTH CLINIC 3	63.52	8,829
4.00			0	RURAL HEALTH CLINIC 4	63.53	9,459
TOTAL RECLASSIFICATIONS FOR CODE F			44,145			44,145

RECLASS CODE: G
EXPLANATION : ADMIN & HOUSEKEEPING TIME - CLINICS

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	165,711	RURAL HEALTH CLINIC	63.50	26,170
2.00	HOUSEKEEPING	10	7,123	RURAL HEALTH CLINIC 2	63.51	67,640
3.00			0	RURAL HEALTH CLINIC 3	63.52	54,738
4.00			0	RURAL HEALTH CLINIC 4	63.53	24,286
TOTAL RECLASSIFICATIONS FOR CODE G			172,834			172,834

RECLASS CODE: H
EXPLANATION : LAB TIME

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	LABORATORY	44	7,966	RURAL HEALTH CLINIC	63.50	896

RECLASS CODE: H
EXPLANATION : LAB TIME

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
2.00			0	RURAL HEALTH CLINIC 3	63.52	3,188
3.00			0	RURAL HEALTH CLINIC 4	63.53	3,882
4.00	BLOOD STORING, PROCESSING & TR	47	2,013	LABORATORY	44	2,013
TOTAL RECLASSIFICATIONS FOR CODE H			9,979			9,979

RECLASS CODE: I
EXPLANATION : RECLASSIFY ER ADMIN TIME

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	39,546	EMERGENCY	61	39,546
TOTAL RECLASSIFICATIONS FOR CODE I			39,546			39,546

RECLASS CODE: J
EXPLANATION : RECLASSIFY LEASES TO CAPITAL

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	278,465	OPERATION OF PLANT	8	12,180
2.00			0	ADULTS & PEDIATRICS	25	21,642
3.00			0	RADIOLOGY-DIAGNOSTIC	41	188,387
4.00			0	LABORATORY	44	56,256
TOTAL RECLASSIFICATIONS FOR CODE J			278,465			278,465

Health Financial Systems MCRIF32 FOR THOMAS H BOYD CRITICAL ACC HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)
ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL I PROVIDER NO: I PERIOD: I PREPARED 2/14/2011
ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE I 14-1300 I FROM 9/ 1/2009 I WORKSHEET A-7
COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS I I TO 8/31/2010 I PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS PURCHASES	ACQUISITIONS DONATION	ACQUISITIONS TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND	388,754				318,240	70,514	
2	LAND IMPROVEMENTS	36,143					36,143	
3	BUILDINGS & FIXTURE	2,413,971	25,580		25,580	8,200	2,431,351	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	84,028					84,028	
6	MOVABLE EQUIPMENT	1,518,808	52,910		52,910		1,571,718	
7	SUBTOTAL	4,441,704	78,490		78,490	326,440	4,193,754	
8	RECONCILING ITEMS	400,884	51,830		51,830		452,714	
9	TOTAL	4,040,820	26,660		26,660	326,440	3,741,040	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
		GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
1	OLD CAP REL COSTS-BL								
2	OLD CAP REL COSTS-MV								
3	NEW CAP REL COSTS-BL	2,622,036	17,680	2,604,356	.696158	20,447			20,447
4	NEW CAP REL COSTS-MV	1,571,718	435,034	1,136,684	.303842	8,924			8,924
5	TOTAL	4,193,754	452,714	3,741,040	1.000000	29,371			29,371

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	62,018	-5,757		20,447			76,708
4	NEW CAP REL COSTS-MV	102,384	278,465	14,992	8,924			404,765
5	TOTAL	164,402	272,708	14,992	29,371			481,473

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	164,402						164,402
4	NEW CAP REL COSTS-MV							
5	TOTAL	164,402						164,402

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO	WKST. A-7 REF.
		1	2	3	4	5
1	INVST INCOME-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-1,904	NEW CAP REL COSTS-MVBLE E	4	11
5	INVESTMENT INCOME-OTHER	B	-5,859	ADMINISTRATIVE & GENERAL	6	
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE	A	-1,911	ADMINISTRATIVE & GENERAL	6	
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-103,663			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-36,382	DIETARY	11	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS	B	-5,757	NEW CAP REL COSTS-BLDG &	3	10
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-3,662	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			UTILIZATION REVIEW-SNF	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	PROPERTY TAXES	A	-12,944	ADMINISTRATIVE & GENERAL	6	
38	IRS PENALTIES	A	-397	ADMINISTRATIVE & GENERAL	6	
39	LOBBYING EXPENSE (IN DUES)	A	-3,161	ADMINISTRATIVE & GENERAL	6	
40	MISCELLANEOUS INCOME OFFSETS	A	-581	ADMINISTRATIVE & GENERAL	6	
41	MISCELLANEOUS INCOME OFFSETS	B	-56	MEDICAL RECORDS & LIBRARY	17	
42	MISCELLANEOUS INCOME OFFSETS	B	-335	RADIOLOGY-DIAGNOSTIC	41	
43	MISCELLANEOUS INCOME OFFSETS	B	-100	LABORATORY	44	
44	MISCELLANEOUS INCOME OFFSETS	B	-65	MEDICAL SUPPLIES CHARGED	55	
45	MISCELLANEOUS INCOME OFFSETS	B	-365	EMERGENCY	61	
46	MISCELLANEOUS INCOME OFFSETS	B	-452	AMBULANCE SERVICES	65	
47	ER PHYSICIANS - BENEFIT COST	A	-6,884	EMPLOYEE BENEFITS	5	
48	ER PHYSICIANS - BILLING COST	A	-28,626	ADMINISTRATIVE & GENERAL	6	
49	ER PHYSICIANS - BILLING COST	A	-2,345	EMPLOYEE BENEFITS	5	
49.01	EMPLOYEE DISCOUNTS	A	13,515	EMPLOYEE BENEFITS	5	
50	TOTAL (SUM OF LINES 1 THRU 49)		-201,934			

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 14-1300
I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010
I PREPARED 2/14/2011 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFES-SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
1	63 50	RHC MEDICAL DIRECTOR	11,740		11,740				
2	44	PATHOLOGIST	2,500		2,500				
3	61	ER PHYSICIAN/PAS	701,351	103,663	597,688				
5	63 53	RHC MEDICAL DIRECTOR	12,517		12,517				
6	63 51	RHC MEDICAL DIRECTOR	1,600		1,600				
7									
8									
9									
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28									
29									
30									
101		TOTAL	729,708	103,663	626,045				

Health Financial Systems MCRIF32 FOR THOMAS H BOYD CRITICAL ACC HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I 14-1300 I
I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I
I PREPARED 2/14/2011 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO.		COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUSTMENT
	10		11	12	13	14	15	16	17	18
1	63	50	RHC MEDICAL DIRECTOR							
2	44		PATHOLOGIST							
3	61		ER PHYSICIAN/PAS							103,663
5	63	53	RHC MEDICAL DIRECTOR							
6	63	51	RHC MEDICAL DIRECTOR							
7										
8										
9										
10										
11										
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25										
26										
27										
28										
29										
30										
101			TOTAL							103,663

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

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	4
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	60
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	21
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	5.82
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		117.25			
10	AHSEA (SEE INSTRUCTIONS)		67.13			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	33.57	33.57			
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)		478			
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	7,871
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	7,871
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	7,871

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	7,871

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

STANDARD TRAVEL ALLOWANCE

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	705
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	705
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	122
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	827

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	32,088
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	32,088
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

OCCUPATIONAL THERAPY

33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	1,433
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

	STANDARD TRAVEL EXPENSE	
36	THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)	
37	ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)	
38	SUBTOTAL (SUM OF LINES 36 AND 37)	
39	STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)	
40	THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)	
41	ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)	
42	SUBTOTAL (SUM OF LINES 40 AND 41)	
43	OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)	
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES; COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE	
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)	
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)	
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)	

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	7,871
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	1,433
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	9,304
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	8,468

65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	
PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES		
66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	8,468
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	8,468
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 2/14/2011
I 14-1300 I FROM 9/ 1/2009 I NOT A CMS WORKSHEET
I I TO 8/31/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
1	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	NOT ENTERED
2	OLD CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	NOT ENTERED
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	23	DOLLAR VALUE	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
8	OPERATION OF PLANT	7	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF SERVICE	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	5	GROSS SALARIES	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	ENTERED
16	PHARMACY	15	COSTED REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	ENTERED
24	PARAMED ED PRGM	22	ASSIGNED TIME	NOT ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET B PART I

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	OLD CAP REL COSTS-BLDG &	OLD CAP REL COSTS-MVBLE E	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL
			0	1	2	3	4	5	5a.00
		GENERAL SERVICE COST CNTR							
001		OLD CAP REL COSTS-BLDG &							
002		OLD CAP REL COSTS-MVBLE E							
003		NEW CAP REL COSTS-BLDG &	76,708			76,708			
004		NEW CAP REL COSTS-MVBLE E	404,765				404,765		
005		EMPLOYEE BENEFITS	552,719					552,719	
006		ADMINISTRATIVE & GENERAL	1,220,769			5,097	33,655	71,798	1,331,319
008		OPERATION OF PLANT	233,900			2,732	2,974	5,886	245,492
009		LAUNDRY & LINEN SERVICE	32,606			2,136	9,883	2,780	47,405
010		HOUSEKEEPING	99,945			509	1,426	6,867	108,747
011		DIETARY	183,163			6,829	3,980	16,256	210,228
012		CAFETERIA				766	2,299		3,065
014		NURSING ADMINISTRATION	138,419			890		4,078	143,387
015		CENTRAL SERVICES & SUPPLY				1,527			1,527
016		PHARMACY				727			727
017		MEDICAL RECORDS & LIBRARY	153,556			1,922	18,925	15,890	190,293
024		PARAMED ED PRGM							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,314,034			25,827	50,797	131,302	1,521,960
031		SUBPROVIDER							
035		NURSING FACILITY							
		ANCILLARY SRVC COST CNTRS							
041		RADIOLOGY-DIAGNOSTIC	527,032			4,432	71,633	38,157	641,254
044		LABORATORY	511,684			1,578	139,980	26,322	679,564
046		WHOLE BLOOD & PACKED RED							
047		BLOOD STORING, PROCESSING	17,418						17,418
048		INTRAVENOUS THERAPY							
050		PHYSICAL THERAPY	164,901			3,855	37,806	15,413	221,975
053		ELECTROCARDIOLOGY	42,803				6,884		49,687
055		MEDICAL SUPPLIES CHARGED	91,159					2,161	93,320
055	30	IMPL. DEV. CHARGED TO PAT							
056		DRUGS CHARGED TO PATIENTS	312,218				108		312,326
059		OTHER ANCILLARY SERVICE C							
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	7,307					774	8,081
061		EMERGENCY	1,082,241			6,536	12,316	52,398	1,153,491
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	135,928			2,446	2,292	15,189	155,855
063	51	RURAL HEALTH CLINIC 2	343,225			2,848	8,686	43,475	398,234
063	52	RURAL HEALTH CLINIC 3	262,080					30,589	292,669
063	53	RURAL HEALTH CLINIC 4	215,173			4,467		20,026	239,666
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	545,483			1,584	1,121	48,358	596,546
068		OTHER REIMBURSABLE COST C							
		SPEC PURPOSE COST CENTERS							
092		AMBULATORY SURGICAL CENTE							
094		OTHER SPECIAL PURPOSE (SP							
095		SUBTOTALS	8,669,236			76,708	404,765	547,719	8,664,236
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
097		RESEARCH							
098		PHYSICIANS' PRIVATE OFFIC	45,545					5,000	50,545
098	01	JAIL MEALS							
098	02	OUTPATIENT MEALS							
098	03	IDLE SPACE							
099		NONPAID WORKERS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	8,714,781			76,708	404,765	552,719	8,714,781

		COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
			6	8	9	10	11	12	14
		GENERAL SERVICE COST CNTR							
001		OLD CAP REL COSTS-BLDG &							
002		OLD CAP REL COSTS-MVBLE E							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL	1,331,319						
008		OPERATION OF PLANT	44,265	289,757					
009		LAUNDRY & LINEN SERVICE	8,548	8,406	64,359				
010		HOUSEKEEPING	19,608	2,003	6,240	136,598			
011		DIETARY	37,906	26,872	53	1,060	276,119		
012		CAFETERIA	553	3,016			95,543	102,177	
014		NURSING ADMINISTRATION	25,854	3,504				928	173,673
015		CENTRAL SERVICES & SUPPLY	275	6,010					
016		PHARMACY	131	2,861					
017		MEDICAL RECORDS & LIBRARY	34,312	7,563		837		3,615	
024		PARAMED ED PRGM							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	274,426	82,807	44,964	86,381	122,547	29,872	124,669
031		SUBPROVIDER							
035		NURSING FACILITY							
		ANCILLARY SRVC COST CNTRS							
041		RADIOLOGY-DIAGNOSTIC	115,625	17,439	2,249	4,039		8,681	
044		LABORATORY	122,533	6,210		2,794		5,988	
046		WHOLE BLOOD & PACKED RED							
047		BLOOD STORING, PROCESSING	3,141						
048		INTRAVENOUS THERAPY							
050		PHYSICAL THERAPY	40,025	15,170	2,294	1,097		3,506	
053		ELECTROCARDIOLOGY	8,959						1,269
055		MEDICAL SUPPLIES CHARGED	16,827					492	
055	30	IMPL. DEV. CHARGED TO PAT							
056		DRUGS CHARGED TO PATIENTS	56,316			2,901			
059		OTHER ANCILLARY SERVICE C							
		OUTPAT SERVICE COST CNTRS							
060		CLINIC	1,457					176	
061		EMERGENCY	207,987	25,719	7,169	10,311		11,920	47,735
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	28,102		58	2,608		3,455	
063	51	RURAL HEALTH CLINIC 2	71,806	11,207		9,951		9,890	
063	52	RURAL HEALTH CLINIC 3	52,771			6,040		6,959	
063	53	RURAL HEALTH CLINIC 4	43,214		3	4,072		4,556	
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	107,564	6,232	1,329	1,075		11,001	
068		OTHER REIMBURSABLE COST C							
		SPEC PURPOSE COST CENTERS							
092		AMBULATORY SURGICAL CENTE							
094		OTHER SPECIAL PURPOSE (SP							
095		SUBTOTALS	1,322,205	225,019	64,359	133,166	218,090	101,039	173,673
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
097		RESEARCH							
098		PHYSICIANS' PRIVATE OFFIC	9,114	45,909		3,432		1,138	
098	01	JAIL MEALS					58,029		
098	02	OUTPATIENT MEALS							
098	03	IDLE SPACE		18,829					
099		NONPAID WORKERS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	1,331,319	289,757	64,359	136,598	276,119	102,177	173,673

		COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
			15	16	17	24	25	26	27
		GENERAL SERVICE COST CNTR							
001		OLD CAP REL COSTS-BLDG &							
002		OLD CAP REL COSTS-MVBLE E							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
008		OPERATION OF PLANT							
009		LAUNDRY & LINEN SERVICE							
010		HOUSEKEEPING							
011		DIETARY							
012		CAFETERIA							
014		NURSING ADMINISTRATION							
015		CENTRAL SERVICES & SUPPLY	7,812						
016		PHARMACY		3,719					
017		MEDICAL RECORDS & LIBRARY			236,620				
024		PARAMED ED PRGM							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS			102,149		2,389,775		2,389,775
031		SUBPROVIDER							
035		NURSING FACILITY							
		ANCILLARY SRVC COST CNTRS							
041		RADIOLOGY-DIAGNOSTIC			60,697		849,984		849,984
044		LABORATORY					817,089		817,089
046		WHOLE BLOOD & PACKED RED							
047		BLOOD STORING, PROCESSING					20,559		20,559
048		INTRAVENOUS THERAPY							
050		PHYSICAL THERAPY			12,337		296,404		296,404
053		ELECTROCARDIOLOGY			9,869		69,784		69,784
055		MEDICAL SUPPLIES CHARGED	7,812				118,451		118,451
055	30	IMPL. DEV. CHARGED TO PAT							
056		DRUGS CHARGED TO PATIENTS		3,719			375,262		375,262
059		OTHER ANCILLARY SERVICE C							
		OUTPAT SERVICE COST CNTRS							
060		CLINIC			1,234		10,948		10,948
061		EMERGENCY			50,334		1,514,666		1,514,666
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC					190,078		190,078
063	51	RURAL HEALTH CLINIC 2					501,088		501,088
063	52	RURAL HEALTH CLINIC 3					358,439		358,439
063	53	RURAL HEALTH CLINIC 4					291,511		291,511
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES					723,747		723,747
068		OTHER REIMBURSABLE COST C							
		SPEC PURPOSE COST CENTERS							
092		AMBULATORY SURGICAL CENTE							
094		OTHER SPECIAL PURPOSE (SP							
095		SUBTOTALS	7,812	3,719	236,620		8,527,785		8,527,785
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
097		RESEARCH							
098		PHYSICIANS' PRIVATE OFFIC					110,138		110,138
098	01	JAIL MEALS					58,029	-18,435	39,594
098	02	OUTPATIENT MEALS							
098	03	IDLE SPACE					18,829		18,829
099		NONPAID WORKERS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	7,812	3,719	236,620		8,714,781	-18,435	8,696,346

ALLOCATION OF NEW CAPITAL RELATED COSTS | PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET B PART III

	COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	OLD CAP REL COSTS-BLDG &	OLD CAP REL COSTS-MVBLE E	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS
		0	1	2	3	4	4a	5
	GENERAL SERVICE COST CNTR							
001	OLD CAP REL COSTS-BLDG &							
002	OLD CAP REL COSTS-MVBLE E							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL				5,097	33,655	38,752	
008	OPERATION OF PLANT				2,732	2,974	5,706	
009	LAUNDRY & LINEN SERVICE				2,136	9,883	12,019	
010	HOUSEKEEPING				509	1,426	1,935	
011	DIETARY				6,829	3,980	10,809	
012	CAFETERIA				766	2,299	3,065	
014	NURSING ADMINISTRATION				890		890	
015	CENTRAL SERVICES & SUPPLY				1,527		1,527	
016	PHARMACY				727		727	
017	MEDICAL RECORDS & LIBRARY				1,922	18,925	20,847	
024	PARAMED ED PRGM							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS				25,827	50,797	76,624	
031	SUBPROVIDER							
035	NURSING FACILITY							
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC				4,432	71,633	76,065	
044	LABORATORY				1,578	139,980	141,558	
046	WHOLE BLOOD & PACKED RED							
047	BLOOD STORING, PROCESSING							
048	INTRAVENOUS THERAPY							
050	PHYSICAL THERAPY				3,855	37,806	41,661	
053	ELECTROCARDIOLOGY					6,884	6,884	
055	MEDICAL SUPPLIES CHARGED							
055 30	IMPL. DEV. CHARGED TO PAT							
056	DRUGS CHARGED TO PATIENTS					108	108	
059	OTHER ANCILLARY SERVICE C							
	OUTPAT SERVICE COST CNTRS							
060	CLINIC							
061	EMERGENCY				6,536	12,316	18,852	
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC				2,446	2,292	4,738	
063 51	RURAL HEALTH CLINIC 2				2,848	8,686	11,534	
063 52	RURAL HEALTH CLINIC 3							
063 53	RURAL HEALTH CLINIC 4				4,467		4,467	
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES				1,584	1,121	2,705	
068	OTHER REIMBURSABLE COST C							
	SPEC PURPOSE COST CENTERS							
092	AMBULATORY SURGICAL CENTE							
094	OTHER SPECIAL PURPOSE (SP							
095	SUBTOTALS				76,708	404,765	481,473	
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
097	RESEARCH							
098	PHYSICIANS' PRIVATE OFFIC							
098 01	JAIL MEALS							
098 02	OUTPATIENT MEALS							
098 03	IDLE SPACE							
099	NONPAID WORKERS							
100	OTHER NONREIMBURSABLE COS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL				76,708	404,765	481,473	

	COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
		6	8	9	10	11	12	14
	GENERAL SERVICE COST CNTR							
001	OLD CAP REL COSTS-BLDG &							
002	OLD CAP REL COSTS-MVBLE E							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL	38,752						
008	OPERATION OF PLANT	1,288	6,994					
009	LAUNDRY & LINEN SERVICE	249	203	12,471				
010	HOUSEKEEPING	571	48	1,209	3,763			
011	DIETARY	1,103	649	10	29	12,600		
012	CAFETERIA	16	73			4,360	7,514	
014	NURSING ADMINISTRATION	752	85				68	1,795
015	CENTRAL SERVICES & SUPPLY	8	145					
016	PHARMACY	4	69					
017	MEDICAL RECORDS & LIBRARY	999	183		23		266	
024	PARAMED ED PRGM							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	7,991	1,998	8,712	2,380	5,592	2,197	1,289
031	SUBPROVIDER							
035	NURSING FACILITY							
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC	3,365	421	436	111		638	
044	LABORATORY	3,566	150		77		440	
046	WHOLE BLOOD & PACKED RED							
047	BLOOD STORING, PROCESSING	91						
048	INTRAVENOUS THERAPY							
050	PHYSICAL THERAPY	1,165	366	445	30		258	
053	ELECTROCARDIOLOGY	261						13
055	MEDICAL SUPPLIES CHARGED	490					36	
055	30 IMPL. DEV. CHARGED TO PAT							
056	DRUGS CHARGED TO PATIENTS	1,639			80			
059	OTHER ANCILLARY SERVICE C							
	OUTPAT SERVICE COST CNTRS							
060	CLINIC	42					13	
061	EMERGENCY	6,054	621	1,389	284		877	493
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063	50 RURAL HEALTH CLINIC	818		11	72		254	
063	51 RURAL HEALTH CLINIC 2	2,090	271		274		727	
063	52 RURAL HEALTH CLINIC 3	1,536			166		512	
063	53 RURAL HEALTH CLINIC 4	1,258		1	112		335	
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES	3,131	150	258	30		809	
068	OTHER REIMBURSABLE COST C							
	SPEC PURPOSE COST CENTERS							
092	AMBULATORY SURGICAL CENTE							
094	OTHER SPECIAL PURPOSE (SP							
095	SUBTOTALS	38,487	5,432	12,471	3,668	9,952	7,430	1,795
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
097	RESEARCH							
098	PHYSICIANS' PRIVATE OFFIC	265	1,108		95		84	
098	01 JAIL MEALS					2,648		
098	02 OUTPATIENT MEALS							
098	03 IDLE SPACE		454					
099	NONPAID WORKERS							
100	OTHER NONREIMBURSABLE COS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	38,752	6,994	12,471	3,763	12,600	7,514	1,795

		COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
			15	16	17	24	25	26	27
		GENERAL SERVICE COST CNTR							
001		OLD CAP REL COSTS-BLDG &							
002		OLD CAP REL COSTS-MVBLE E							
003		NEW CAP REL COSTS-BLDG &							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL							
008		OPERATION OF PLANT							
009		LAUNDRY & LINEN SERVICE							
010		HOUSEKEEPING							
011		DIETARY							
012		CAFETERIA							
014		NURSING ADMINISTRATION							
015		CENTRAL SERVICES & SUPPLY	1,680						
016		PHARMACY		800					
017		MEDICAL RECORDS & LIBRARY			22,318				
024		PARAMED ED PRGM							
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS			9,634		116,417		116,417
031		SUBPROVIDER							
035		NURSING FACILITY							
		ANCILLARY SRVC COST CNTRS							
041		RADIOLOGY-DIAGNOSTIC			5,725		86,761		86,761
044		LABORATORY					145,791		145,791
046		WHOLE BLOOD & PACKED RED							
047		BLOOD STORING, PROCESSING					91		91
048		INTRAVENOUS THERAPY							
050		PHYSICAL THERAPY			1,164		45,089		45,089
053		ELECTROCARDIOLOGY			931		8,089		8,089
055		MEDICAL SUPPLIES CHARGED	1,680				2,206		2,206
055	30	IMPL. DEV. CHARGED TO PAT							
056		DRUGS CHARGED TO PATIENTS		800			2,627		2,627
059		OTHER ANCILLARY SERVICE C							
		OUTPAT SERVICE COST CNTRS							
060		CLINIC			116		171		171
061		EMERGENCY			4,748		33,318		33,318
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC					5,893		5,893
063	51	RURAL HEALTH CLINIC 2					14,896		14,896
063	52	RURAL HEALTH CLINIC 3					2,214		2,214
063	53	RURAL HEALTH CLINIC 4					6,173		6,173
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES					7,083		7,083
068		OTHER REIMBURSABLE COST C							
		SPEC PURPOSE COST CENTERS							
092		AMBULATORY SURGICAL CENTE							
094		OTHER SPECIAL PURPOSE (SP							
095		SUBTOTALS	1,680	800	22,318		476,819		476,819
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
097		RESEARCH							
098		PHYSICIANS' PRIVATE OFFIC					1,552		1,552
098	01	JAIL MEALS					2,648		2,648
098	02	OUTPATIENT MEALS							
098	03	IDLE SPACE					454		454
099		NONPAID WORKERS							
100		OTHER NONREIMBURSABLE COS							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	1,680	800	22,318		481,473		481,473

	COST CENTER DESCRIPTION	OLD CAP REL COSTS-BLDG & (SQUARE FEET)	OLD CAP REL COSTS-MVBLE E (DOLLAR VALUE)	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE E (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION
		1	2	3	4	5	6a.00
	GENERAL SERVICE COST						
001	OLD CAP REL COSTS-BLD						
002	OLD CAP REL COSTS-MVB						
003	NEW CAP REL COSTS-BLD			40,832			
004	NEW CAP REL COSTS-MVB				63,563		
005	EMPLOYEE BENEFITS					4,871,479	
006	ADMINISTRATIVE & GENE			2,713	5,285	632,802	-1,331,319
008	OPERATION OF PLANT			1,454	467	51,879	
009	LAUNDRY & LINEN SERVI			1,137	1,552	24,500	
010	HOUSEKEEPING			271	224	60,525	
011	DIETARY			3,635	625	143,276	
012	CAFETERIA			408	361		
014	NURSING ADMINISTRATIO			474		35,944	
015	CENTRAL SERVICES & SU			813			
016	PHARMACY			387			
017	MEDICAL RECORDS & LIB			1,023	2,972	140,053	
024	PARAMED ED PRGM						
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS			13,748	7,977	1,157,240	
031	SUBPROVIDER						
035	NURSING FACILITY						
	ANCILLARY SRVC COST C						
041	RADIOLOGY-DIAGNOSTIC			2,359	11,249	336,300	
044	LABORATORY			840	21,982	231,997	
046	WHOLE BLOOD & PACKED						
047	BLOOD STORING, PROCES						
048	INTRAVENOUS THERAPY						
050	PHYSICAL THERAPY			2,052	5,937	135,845	
053	ELECTROCARDIOLOGY				1,081		
055	MEDICAL SUPPLIES CHAR					19,049	
055 30	IMPL. DEV. CHARGED TO						
056	DRUGS CHARGED TO PATI				17		
059	OTHER ANCILLARY SERVI						
	OUTPAT SERVICE COST C						
060	CLINIC					6,820	
061	EMERGENCY			3,479	1,934	461,820	
062	OBSERVATION BEDS (NON						
063	OTHER OUTPATIENT SERV						
063 50	RURAL HEALTH CLINIC			1,302	360	133,870	
063 51	RURAL HEALTH CLINIC 2			1,516	1,364	383,173	
063 52	RURAL HEALTH CLINIC 3					269,603	
063 53	RURAL HEALTH CLINIC 4			2,378		176,500	
	OTHER REIMBURS COST C						
065	AMBULANCE SERVICES			843	176	426,213	
068	OTHER REIMBURSABLE CO						
	SPEC PURPOSE COST CEN						
092	AMBULATORY SURGICAL C						
094	OTHER SPECIAL PURPOSE						
095	SUBTOTALS			40,832	63,563	4,827,409	-1,331,319
	NONREIMBURS COST CENT						
096	GIFT, FLOWER, COFFEE						
097	RESEARCH						
098	PHYSICIANS' PRIVATE O					44,070	
098 01	JAIL MEALS						
098 02	OUTPATIENT MEALS						
098 03	IDLE SPACE						
099	NONPAID WORKERS						
100	OTHER NONREIMBURSABLE						
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)			76,708	404,765	552,719	
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)			1.878625	6.367934	.113460	
105	COST TO BE ALLOCATED (WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107	COST TO BE ALLOCATED (WRKSHT B, PART III						
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)						

		COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE) FEET	LAUNDRY & LINEN SERVICE (POUNDS OF) LAUNDRY	HOUSEKEEPING (HOURS OF) SERVICE	DIETARY (MEALS)ERVED	CAFETERIA S(GROSS)ALARIES	NURSING ADMINISTRATION S(DIRECT)SING HRS	NR)
			6	8	9	10	11	12	14	
		GENERAL SERVICE COST								
001		OLD CAP REL COSTS-BLD								
002		OLD CAP REL COSTS-MVB								
003		NEW CAP REL COSTS-BLD								
004		NEW CAP REL COSTS-MVB								
005		EMPLOYEE BENEFITS								
006		ADMINISTRATIVE & GENE	7,383,462							
008		OPERATION OF PLANT	245,492	39,195						
009		LAUNDRY & LINEN SERVI	47,405	1,137	67,407					
010		HOUSEKEEPING	108,747	271	6,535	89,557				
011		DIETARY	210,228	3,635	56	695	25,062			
012		CAFETERIA	3,065	408			8,672	3,958,497		
014		NURSING ADMINISTRATIO	143,387	474				35,944	40,381	
015		CENTRAL SERVICES & SU	1,527	813						
016		PHARMACY	727	387						
017		MEDICAL RECORDS & LIB	190,293	1,023		549		140,053		
024		PARAMED ED PRGM								
		INPAT ROUTINE SRVC CN								
025		ADULTS & PEDIATRICS	1,521,960	11,201	47,092	56,633	11,123	1,157,240	28,987	
031		SUBPROVIDER								
035		NURSING FACILITY								
		ANCILLARY SRVC COST C								
041		RADIOLOGY-DIAGNOSTIC	641,254	2,359	2,356	2,648		336,300		
044		LABORATORY	679,564	840		1,832		231,997		
046		WHOLE BLOOD & PACKED								
047		BLOOD STORING, PROCES	17,418							
048		INTRAVENOUS THERAPY								
050		PHYSICAL THERAPY	221,975	2,052	2,403	719		135,845		
053		ELECTROCARDIOLOGY	49,687						295	
055		MEDICAL SUPPLIES CHAR	93,320					19,049		
055	30	IMPL. DEV. CHARGED TO								
056		DRUGS CHARGED TO PATI	312,326			1,902				
059		OTHER ANCILLARY SERVI								
		OUTPAT SERVICE COST C								
060		CLINIC	8,081					6,820		
061		EMERGENCY	1,153,491	3,479	7,509	6,760		461,820	11,099	
062		OBSERVATION BEDS (NON								
063		OTHER OUTPATIENT SERV								
063	50	RURAL HEALTH CLINIC	155,855		61	1,710		133,870		
063	51	RURAL HEALTH CLINIC 2	398,234	1,516		6,524		383,173		
063	52	RURAL HEALTH CLINIC 3	292,669			3,960		269,603		
063	53	RURAL HEALTH CLINIC 4	239,666		3	2,670		176,500		
		OTHER REIMBURS COST C								
065		AMBULANCE SERVICES	596,546	843	1,392	705		426,213		
068		OTHER REIMBURSABLE CO								
		SPEC PURPOSE COST CEN								
092		AMBULATORY SURGICAL C								
094		OTHER SPECIAL PURPOSE								
095		SUBTOTALS	7,332,917	30,438	67,407	87,307	19,795	3,914,427	40,381	
		NONREIMBURS COST CENT								
096		GIFT, FLOWER, COFFEE								
097		RESEARCH								
098		PHYSICIANS' PRIVATE O	50,545	6,210		2,250		44,070		
098	01	JAIL MEALS					5,267			
098	02	OUTPATIENT MEALS								
098	03	IDLE SPACE		2,547						
099		NONPAID WORKERS								
100		OTHER NONREIMBURSABLE								
101		CROSS FOOT ADJUSTMENT								
102		NEGATIVE COST CENTER								
103		COST TO BE ALLOCATED (WRKSHT B, PART I)	1,331,319	289,757	64,359	136,598	276,119	102,177	173,673	
104		UNIT COST MULTIPLIER (WRKSHT B, PT I)	.180311	7.392703	.954782	1.525263	11.017437	.025812	4.300859	
105		COST TO BE ALLOCATED (WRKSHT B, PART II)								
106		UNIT COST MULTIPLIER (WRKSHT B, PT II)								
107		COST TO BE ALLOCATED (WRKSHT B, PART III	38,752	6,994	12,471	3,763	12,600	7,514	1,795	
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)	.005248	.178441	.185010	.042018	.502753	.001898	.044452	

	COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY (COSTED EQUIS.)	PHARMACY (COSTED EQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)
		15	16	17	24
	GENERAL SERVICE COST				
001	OLD CAP REL COSTS-BLD				
002	OLD CAP REL COSTS-MVB				
003	NEW CAP REL COSTS-BLD				
004	NEW CAP REL COSTS-MVB				
005	EMPLOYEE BENEFITS				
006	ADMINISTRATIVE & GENE				
008	OPERATION OF PLANT				
009	LAUNDRY & LINEN SERVI				
010	HOUSEKEEPING				
011	DIETARY				
012	CAFETERIA				
014	NURSING ADMINISTRATIO				
015	CENTRAL SERVICES & SU	100			
016	PHARMACY		100		
017	MEDICAL RECORDS & LIB			959	
024	PARAMED ED PRGM				
	INPAT ROUTINE SRVC CN				
025	ADULTS & PEDIATRICS			414	
031	SUBPROVIDER				
035	NURSING FACILITY				
	ANCILLARY SRVC COST C				
041	RADIOLOGY-DIAGNOSTIC			246	
044	LABORATORY				
046	WHOLE BLOOD & PACKED				
047	BLOOD STORING, PROCES				
048	INTRAVENOUS THERAPY				
050	PHYSICAL THERAPY			50	
053	ELECTROCARDIOLOGY			40	
055	MEDICAL SUPPLIES CHAR	100			
055 30	IMPL. DEV. CHARGED TO				
056	DRUGS CHARGED TO PATI		100		
059	OTHER ANCILLARY SERVI				
	OUTPAT SERVICE COST C				
060	CLINIC			5	
061	EMERGENCY			204	
062	OBSERVATION BEDS (NON				
063	OTHER OUTPATIENT SERV				
063 50	RURAL HEALTH CLINIC				
063 51	RURAL HEALTH CLINIC 2				
063 52	RURAL HEALTH CLINIC 3				
063 53	RURAL HEALTH CLINIC 4				
	OTHER REIMBURS COST C				
065	AMBULANCE SERVICES				
068	OTHER REIMBURSABLE CO				
	SPEC PURPOSE COST CEN				
092	AMBULATORY SURGICAL C				
094	OTHER SPECIAL PURPOSE				
095	SUBTOTALS	100	100	959	
	NONREIMBURS COST CENT				
096	GIFT, FLOWER, COFFEE				
097	RESEARCH				
098	PHYSICIANS' PRIVATE O				
098 01	JAIL MEALS				
098 02	OUTPATIENT MEALS				
098 03	IDLE SPACE				
099	NONPAID WORKERS				
100	OTHER NONREIMBURSABLE				
101	CROSS FOOT ADJUSTMENT				
102	NEGATIVE COST CENTER				
103	COST TO BE ALLOCATED (PER WRKSHT B, PART	7,812	3,719	236,620	
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	78.120000	37.190000	246.736184	
105	COST TO BE ALLOCATED (PER WRKSHT B, PART				
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)				
107	COST TO BE ALLOCATED (PER WRKSHT B, PART	1,680	800	22,318	
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	16.800000	8.000000	23.272158	

POST STEP DOWN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 2/14/2011
I 14-1300 I FROM 9/ 1/2009 I
I I TO 8/31/2010 I WORKSHEET B-2

	DESCRIPTION	WORKSHEET PART	LINE NO.		AMOUNT
	1	2	3		4
1	ADJ FOR EPO COSTS IN RENAL DIA	1	57		
2	ADJ FOR EPO COSTS IN HOME PROG	1	64		
3	ADJ FOR ARANESP IN RENAL DIALY	1	57		
4	ADJ FOR ARANESP IN HOME PROGRA	1	64		
9	JAIL MEALS	1	98	1	-18,435

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,389,775		2,389,775		
31	SUBPROVIDER					
35	NURSING FACILITY					
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC	849,984		849,984		
44	LABORATORY	817,089		817,089		
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING	20,559		20,559		
48	INTRAVENOUS THERAPY					
50	PHYSICAL THERAPY	296,404		296,404		
53	ELECTROCARDIOLOGY	69,784		69,784		
55	MEDICAL SUPPLIES CHARGED	118,451		118,451		
55 30	IMPL. DEV. CHARGED TO PAT					
56	DRUGS CHARGED TO PATIENTS	375,262		375,262		
59	OTHER ANCILLARY SERVICE C					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	10,948		10,948		
61	EMERGENCY	1,514,666		1,514,666		
62	OBSERVATION BEDS (NON-DIS	317,383		317,383		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	190,078		190,078		
63 51	RURAL HEALTH CLINIC 2	501,088		501,088		
63 52	RURAL HEALTH CLINIC 3	358,439		358,439		
63 53	RURAL HEALTH CLINIC 4	291,511		291,511		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	723,747		723,747		
68	OTHER REIMBURSABLE COST C					
101	SUBTOTAL	8,845,168		8,845,168		
102	LESS OBSERVATION BEDS	317,383		317,383		
103	TOTAL	8,527,785		8,527,785		

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET C PART I

WKST A LINE NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES	OUTPATIENT CHARGES	TOTAL CHARGES	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO
			6	7	8	9	10	11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	1,459,484		1,459,484			
31		SUBPROVIDER						
35		NURSING FACILITY						
		ANCILLARY SRVC COST CNTRS						
41		RADIOLOGY-DIAGNOSTIC	221,386	2,800,377	3,021,763	.281287	.281287	
44		LABORATORY	336,530	2,408,233	2,744,763	.297690	.297690	
46		WHOLE BLOOD & PACKED RED						
47		BLOOD STORING, PROCESSING	20,812	64,854	85,666	.239990	.239990	
48		INTRAVENOUS THERAPY						
50		PHYSICAL THERAPY	92,550	514,606	607,156	.488184	.488184	
53		ELECTROCARDIOLOGY	33,422	559,028	592,450	.117789	.117789	
55		MEDICAL SUPPLIES CHARGED	302,398	181,190	483,588	.244942	.244942	
55	30	IMPL. DEV. CHARGED TO PAT						
56		DRUGS CHARGED TO PATIENTS	577,057	591,293	1,168,350	.321190	.321190	
59		OTHER ANCILLARY SERVICE C						
		OUTPAT SERVICE COST CNTRS						
60		CLINIC		37,421	37,421	.292563	.292563	
61		EMERGENCY	3,536	1,634,191	1,637,727	.924859	.924859	
62		OBSERVATION BEDS (NON-DIS		672,174	672,174	.472174	.472174	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		126,886	126,886	1.498022	1.498022	
63	51	RURAL HEALTH CLINIC 2		442,387	442,387	1.132692	1.132692	
63	52	RURAL HEALTH CLINIC 3		258,899	258,899	1.384474	1.384474	
63	53	RURAL HEALTH CLINIC 4		149,906	149,906	1.944625	1.944625	
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES		999,911	999,911	.723811	.723811	
68		OTHER REIMBURSABLE COST C						
101		SUBTOTAL	3,047,175	11,441,356	14,488,531			
102		LESS OBSERVATION BEDS						
103		TOTAL	3,047,175	11,441,356	14,488,531			

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,389,775		2,389,775		
31	SUBPROVIDER					
35	NURSING FACILITY					
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC	849,984		849,984		
44	LABORATORY	817,089		817,089		
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING	20,559		20,559		
48	INTRAVENOUS THERAPY					
50	PHYSICAL THERAPY	296,404		296,404		
53	ELECTROCARDIOLOGY	69,784		69,784		
55	MEDICAL SUPPLIES CHARGED	118,451		118,451		
55 30	IMPL. DEV. CHARGED TO PAT					
56	DRUGS CHARGED TO PATIENTS	375,262		375,262		
59	OTHER ANCILLARY SERVICE C					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	10,948		10,948		
61	EMERGENCY	1,514,666		1,514,666		
62	OBSERVATION BEDS (NON-DIS	317,383		317,383		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	190,078		190,078		
63 51	RURAL HEALTH CLINIC 2	501,088		501,088		
63 52	RURAL HEALTH CLINIC 3	358,439		358,439		
63 53	RURAL HEALTH CLINIC 4	291,511		291,511		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	723,747		723,747		
68	OTHER REIMBURSABLE COST C					
101	SUBTOTAL	8,845,168		8,845,168		
102	LESS OBSERVATION BEDS	317,383		317,383		
103	TOTAL	8,527,785		8,527,785		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	1,459,484		1,459,484			
31	SUBPROVIDER						
35	NURSING FACILITY						
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC	221,386	2,800,377	3,021,763	.281287	.281287	
44	LABORATORY	336,530	2,408,233	2,744,763	.297690	.297690	
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING	20,812	64,854	85,666	.239990	.239990	
48	INTRAVENOUS THERAPY						
50	PHYSICAL THERAPY	92,550	514,606	607,156	.488184	.488184	
53	ELECTROCARDIOLOGY	33,422	559,028	592,450	.117789	.117789	
55	MEDICAL SUPPLIES CHARGED	302,398	181,190	483,588	.244942	.244942	
55 30	IMPL. DEV. CHARGED TO PAT						
56	DRUGS CHARGED TO PATIENTS	577,057	591,293	1,168,350	.321190	.321190	
59	OTHER ANCILLARY SERVICE C						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		37,421	37,421	.292563	.292563	
61	EMERGENCY	3,536	1,634,191	1,637,727	.924859	.924859	
62	OBSERVATION BEDS (NON-DIS		672,174	672,174	.472174	.472174	
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC		126,886	126,886	1.498022	1.498022	
63 51	RURAL HEALTH CLINIC 2		442,387	442,387	1.132692	1.132692	
63 52	RURAL HEALTH CLINIC 3		258,899	258,899	1.384474	1.384474	
63 53	RURAL HEALTH CLINIC 4		149,906	149,906	1.944625	1.944625	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		999,911	999,911	.723811	.723811	
68	OTHER REIMBURSABLE COST C						
101	SUBTOTAL	3,047,175	11,441,356	14,488,531			
102	LESS OBSERVATION BEDS						
103	TOTAL	3,047,175	11,441,356	14,488,531			

WKST A LINE	NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS						
41		RADIOLOGY-DIAGNOSTIC	849,984	86,761	763,223			849,984
44		LABORATORY	817,089	145,791	671,298			817,089
46		WHOLE BLOOD & PACKED RED						
47		BLOOD STORING, PROCESSING	20,559	91	20,468			20,559
48		INTRAVENOUS THERAPY						
50		PHYSICAL THERAPY	296,404	45,089	251,315			296,404
53		ELECTROCARDIOLOGY	69,784	8,089	61,695			69,784
55		MEDICAL SUPPLIES CHARGED	118,451	2,206	116,245			118,451
55	30	IMPL. DEV. CHARGED TO PAT						
56		DRUGS CHARGED TO PATIENTS	375,262	2,627	372,635			375,262
59		OTHER ANCILLARY SERVICE C						
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	10,948	171	10,777			10,948
61		EMERGENCY	1,514,666	33,318	1,481,348			1,514,666
62		OBSERVATION BEDS (NON-DIS	317,383		317,383			317,383
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	190,078	5,893	184,185			190,078
63	51	RURAL HEALTH CLINIC 2	501,088	14,896	486,192			501,088
63	52	RURAL HEALTH CLINIC 3	358,439	2,214	356,225			358,439
63	53	RURAL HEALTH CLINIC 4	291,511	6,173	285,338			291,511
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	723,747	7,083	716,664			723,747
68		OTHER REIMBURSABLE COST C						
101		SUBTOTAL	6,455,393	360,402	6,094,991			6,455,393
102		LESS OBSERVATION BEDS	317,383		317,383			317,383
103		TOTAL	6,138,010	360,402	5,777,608			6,138,010

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
41		RADIOLOGY-DIAGNOSTIC	3,021,763	.281287	.281287
44		LABORATORY	2,744,763	.297690	.297690
46		WHOLE BLOOD & PACKED RED			
47		BLOOD STORING, PROCESSING	85,666	.239990	.239990
48		INTRAVENOUS THERAPY			
50		PHYSICAL THERAPY	607,156	.488184	.488184
53		ELECTROCARDIOLOGY	592,450	.117789	.117789
55		MEDICAL SUPPLIES CHARGED	483,588	.244942	.244942
55	30	IMPL. DEV. CHARGED TO PAT			
56		DRUGS CHARGED TO PATIENTS	1,168,350	.321190	.321190
59		OTHER ANCILLARY SERVICE C			
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	37,421	.292563	.292563
61		EMERGENCY	1,637,727	.924859	.924859
62		OBSERVATION BEDS (NON-DIS	672,174	.472174	.472174
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	126,886	1.498022	1.498022
63	51	RURAL HEALTH CLINIC 2	442,387	1.132692	1.132692
63	52	RURAL HEALTH CLINIC 3	258,899	1.384474	1.384474
63	53	RURAL HEALTH CLINIC 4	149,906	1.944625	1.944625
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES	999,911	.723811	.723811
68		OTHER REIMBURSABLE COST C			
101		SUBTOTAL	13,029,047		
102		LESS OBSERVATION BEDS	672,174		
103		TOTAL	12,356,873		

WKST A LINE	NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS						
41		RADIOLOGY-DIAGNOSTIC	849,984	86,761	763,223			849,984
44		LABORATORY	817,089	145,791	671,298			817,089
46		WHOLE BLOOD & PACKED RED						
47		BLOOD STORING, PROCESSING	20,559	91	20,468			20,559
48		INTRAVENOUS THERAPY						
50		PHYSICAL THERAPY	296,404	45,089	251,315			296,404
53		ELECTROCARDIOLOGY	69,784	8,089	61,695			69,784
55		MEDICAL SUPPLIES CHARGED	118,451	2,206	116,245			118,451
55	30	IMPL. DEV. CHARGED TO PAT						
56		DRUGS CHARGED TO PATIENTS	375,262	2,627	372,635			375,262
59		OTHER ANCILLARY SERVICE C						
		OUTPAT SERVICE COST CNTRS						
60		CLINIC	10,948	171	10,777			10,948
61		EMERGENCY	1,514,666	33,318	1,481,348			1,514,666
62		OBSERVATION BEDS (NON-DIS	317,383		317,383			317,383
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	190,078	5,893	184,185			190,078
63	51	RURAL HEALTH CLINIC 2	501,088	14,896	486,192			501,088
63	52	RURAL HEALTH CLINIC 3	358,439	2,214	356,225			358,439
63	53	RURAL HEALTH CLINIC 4	291,511	6,173	285,338			291,511
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	723,747	7,083	716,664			723,747
68		OTHER REIMBURSABLE COST C						
101		SUBTOTAL	6,455,393	360,402	6,094,991			6,455,393
102		LESS OBSERVATION BEDS	317,383		317,383			317,383
103		TOTAL	6,138,010	360,402	5,777,608			6,138,010

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
41		RADIOLOGY-DIAGNOSTIC	3,021,763	.281287	.281287
44		LABORATORY	2,744,763	.297690	.297690
46		WHOLE BLOOD & PACKED RED			
47		BLOOD STORING, PROCESSING	85,666	.239990	.239990
48		INTRAVENOUS THERAPY			
50		PHYSICAL THERAPY	607,156	.488184	.488184
53		ELECTROCARDIOLOGY	592,450	.117789	.117789
55		MEDICAL SUPPLIES CHARGED	483,588	.244942	.244942
55	30	IMPL. DEV. CHARGED TO PAT			
56		DRUGS CHARGED TO PATIENTS	1,168,350	.321190	.321190
59		OTHER ANCILLARY SERVICE C			
		OUTPAT SERVICE COST CNTRS			
60		CLINIC	37,421	.292563	.292563
61		EMERGENCY	1,637,727	.924859	.924859
62		OBSERVATION BEDS (NON-DIS	672,174	.472174	.472174
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	126,886	1.498022	1.498022
63	51	RURAL HEALTH CLINIC 2	442,387	1.132692	1.132692
63	52	RURAL HEALTH CLINIC 3	258,899	1.384474	1.384474
63	53	RURAL HEALTH CLINIC 4	149,906	1.944625	1.944625
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES	999,911	.723811	.723811
68		OTHER REIMBURSABLE COST C			
101		SUBTOTAL	13,029,047		
102		LESS OBSERVATION BEDS	672,174		
103		TOTAL	12,356,873		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011
I COMPONENT NO: 14-1300 I WORKSHEET D PART V

TITLE XVIII, PART B HOSPITAL

(A)		Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9) 1	Cost/Charge Ratio (C, Pt I, col. 9) 1.01	Cost/Charge Ratio (C, Pt II, col. 9) 1.02	Outpatient Ambulatory Surgical Ctr 2	Outpatient Radialogy 3
		ANCILLARY SRVC COST CNTRS					
41		RADIOLOGY-DIAGNOSTIC	.281287		.281287		
44		LABORATORY	.297690		.297690		
46		WHOLE BLOOD & PACKED RED BLOOD CELLS					
47		BLOOD STORING, PROCESSING & TRANS.	.239990		.239990		
48		INTRAVENOUS THERAPY					
50		PHYSICAL THERAPY	.488184		.488184		
53		ELECTROCARDIOLOGY	.117789		.117789		
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.244942		.244942		
55	30	IMPL. DEV. CHARGED TO PATIENT					
56		DRUGS CHARGED TO PATIENTS	.321190		.321190		
59		OTHER ANCILLARY SERVICE COST CENTERS					
		OUTPAT SERVICE COST CNTRS					
60		CLINIC	.292563		.292563		
61		EMERGENCY	.924859		.924859		
62		OBSERVATION BEDS (NON-DISTINCT PART)	.472174		.472174		
63		OTHER OUTPATIENT SERVICE COST CENTER					
63	50	RURAL HEALTH CLINIC					
63	51	RURAL HEALTH CLINIC 2					
63	52	RURAL HEALTH CLINIC 3					
63	53	RURAL HEALTH CLINIC 4					
		OTHER REIMBURS COST CNTRS					
65		AMBULANCE SERVICES	.723811		.723811		
68		OTHER REIMBURSABLE COST CENTERS					
101		SUBTOTAL					
102		CRNA CHARGES					
103		LESS PBP CLINIC LAB SVCS-					
		PROGRAM ONLY CHARGES					
104		NET CHARGES					

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET D PART V I COMPONENT NO: 14-1300 I I

TITLE XVIII, PART B HOSPITAL

(A)		Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic
	Cost Center Description	4	5	6	7	8
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC		947,652			
44	LABORATORY		1,193,838			
46	WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	BLOOD STORING, PROCESSING & TRANS.		35,481			
48	INTRAVENOUS THERAPY					
50	PHYSICAL THERAPY		159,905			
53	ELECTROCARDIOLOGY		279,860			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		140,297			
55 30	IMPL. DEV. CHARGED TO PATIENT					
56	DRUGS CHARGED TO PATIENTS		282,180			
59	OTHER ANCILLARY SERVICE COST CENTERS					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY		773,005			
62	OBSERVATION BEDS (NON-DISTINCT PART)		190,599			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
63 51	RURAL HEALTH CLINIC 2					
63 52	RURAL HEALTH CLINIC 3					
63 53	RURAL HEALTH CLINIC 4					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
68	OTHER REIMBURSABLE COST CENTERS					
101	SUBTOTAL		4,002,817			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		4,002,817			

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET D I PART V I COMPONENT NO: 14-1300

TITLE XVIII, PART B HOSPITAL

(A)		Cost Center Description	All Other 9	Hospital I/P Part B Charges 10	Hospital I/P Part B Costs 11
		ANCILLARY SRVC COST CNTRS			
41		RADIOLOGY-DIAGNOSTIC	266,562		
44		LABORATORY	355,394		
46		WHOLE BLOOD & PACKED RED BLOOD CELLS			
47		BLOOD STORING, PROCESSING & TRANS.	8,515		
48		INTRAVENOUS THERAPY			
50		PHYSICAL THERAPY	78,063		
53		ELECTROCARDIOLOGY	32,964		
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	34,365		
55	30	IMPL. DEV. CHARGED TO PATIENT			
56		DRUGS CHARGED TO PATIENTS	90,633		
59		OTHER ANCILLARY SERVICE COST CENTERS			
		OUTPAT SERVICE COST CNTRS			
60		CLINIC			
61		EMERGENCY	714,921		
62		OBSERVATION BEDS (NON-DISTINCT PART)	89,996		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
63	51	RURAL HEALTH CLINIC 2			
63	52	RURAL HEALTH CLINIC 3			
63	53	RURAL HEALTH CLINIC 4			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
68		OTHER REIMBURSABLE COST CENTERS			
101		SUBTOTAL	1,671,413		
102		CRNA CHARGES			
103		LESS PBP CLINIC LAB SVCS-			
		PROGRAM ONLY CHARGES			
104		NET CHARGES	1,671,413		

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

I PROVIDER NO:	I PERIOD:	I PREPARED	2/14/2011
I 14-1300	I FROM 9/ 1/2009	I WORKSHEET D	
I COMPONENT NO:	I TO 8/31/2010	I PART VI	
I 14-1300	I	I	

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.321190
2	PROGRAM VACCINE CHARGES	260
3	PROGRAM COSTS	84

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 8/31/2010	PART I
14-1300		

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,702
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,190
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,190
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	348
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	610
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	603
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	951
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	652
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	321
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	581
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	117.51
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	118.46
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,389,775
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	70,859
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	112,655
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,167,495
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,222,280
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	837,302
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	837,302
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.459784
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	703.62
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,222,280

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1,027.12
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	669,682
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	669,682

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

		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	205,980
49	TOTAL PROGRAM INPATIENT COSTS	875,662
	PASS THROUGH COST ADJUSTMENTS	
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	
52	TOTAL PROGRAM EXCLUDABLE COST	
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	
	TARGET AMOUNT AND LIMIT COMPUTATION	
54	PROGRAM DISCHARGES	
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	
	PROGRAM INPATIENT ROUTINE SWING BED COST	
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	329,706
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	596,757
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	926,463
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED	2/14/2011
14-1300	FROM 9/ 1/2009	WORKSHEET	D-1
COMPONENT NO:	TO 8/31/2010	PART	III
14-1300			

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	309
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,027.13
85	OBSERVATION BED COST	317,383

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET D-4

I COMPONENT NO: 14-1300 I I

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		629,773	
31	SUBPROVIDER			
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC	.281287	137,166	38,583
44	LABORATORY	.297690	165,282	49,203
46	WHOLE BLOOD & PACKED RED BLOOD CELLS			
47	BLOOD STORING, PROCESSING & TRANS.	.239990	11,193	2,686
48	INTRAVENOUS THERAPY			
50	PHYSICAL THERAPY	.488184	5,106	2,493
53	ELECTROCARDIOLOGY	.117789	19,411	2,286
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.244942	153,801	37,672
55 30	IMPL. DEV. CHARGED TO PATIENT			
56	DRUGS CHARGED TO PATIENTS	.321190	227,456	73,057
59	OTHER ANCILLARY SERVICE COST CENTERS			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.292563		
61	EMERGENCY	.924859		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.472174		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
63 51	RURAL HEALTH CLINIC 2			
63 52	RURAL HEALTH CLINIC 3			
63 53	RURAL HEALTH CLINIC 4			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
68	OTHER REIMBURSABLE COST CENTERS			
101	TOTAL		719,415	205,980
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		719,415	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET D-4 I COMPONENT NO: 14-Z300 I I

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
31	SUBPROVIDER			
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC	.281287	40,330	11,344
44	LABORATORY	.297690	68,627	20,430
46	WHOLE BLOOD & PACKED RED BLOOD CELLS			
47	BLOOD STORING, PROCESSING & TRANS.	.239990	5,936	1,425
48	INTRAVENOUS THERAPY			
50	PHYSICAL THERAPY	.488184	79,176	38,652
53	ELECTROCARDIOLOGY	.117789	2,233	263
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.244942	148,597	36,398
55 30	IMPL. DEV. CHARGED TO PATIENT			
56	DRUGS CHARGED TO PATIENTS	.321190	189,769	60,952
59	OTHER ANCILLARY SERVICE COST CENTERS			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.292563		
61	EMERGENCY	.924859		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.472174		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
63 51	RURAL HEALTH CLINIC 2			
63 52	RURAL HEALTH CLINIC 3			
63 53	RURAL HEALTH CLINIC 4			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
68	OTHER REIMBURSABLE COST CENTERS			
101	TOTAL		534,668	169,464
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		534,668	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 2/14/2011
14-1300	FROM 9/ 1/2009	WORKSHEET E
COMPONENT NO:	TO 8/31/2010	PART B
14-1300		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	1,671,497
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	1,671,497
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	1,688,212
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	26,350
18.01	CAH ACTUAL BILLED COINSURANCE	558,896
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	1,102,966
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	1,102,966
24	PRIMARY PAYER PAYMENTS	1,549
25	SUBTOTAL	1,101,417
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	132,815
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	132,815
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	100,027
28	SUBTOTAL	1,234,232
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	1,234,232
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	1,533,766
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-299,534
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET E-1 I COMPONENT NO: 14-1300 I I

TITLE XVIII HOSPITAL

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	P A R T B MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			741,171		1,349,759
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01	3/ 5/2010	50,135	3/ 5/2010	159,009
	ADJUSTMENTS TO PROVIDER	.02	8/27/2010	11,996	8/27/2010	24,998
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		62,131		184,007
4	TOTAL INTERIM PAYMENTS			803,302		1,533,766
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01			
		SETTLEMENT TO PROGRAM	.02	64,181		299,534
7	TOTAL MEDICARE PROGRAM LIABILITY			739,121		1,234,232

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: 14-1300 I PERIOD: I FROM 9/ 1/2009 I TO 8/31/2010 I PREPARED 2/14/2011 I WORKSHEET E-1 I COMPONENT NO: 14-Z300 I I

TITLE XVIII SWING BED SNF

	DESCRIPTION			INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	P A R T B MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,124,220		
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.				NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
		ADJUSTMENTS TO PROVIDER	.01	3/ 5/2010	73,458		
		ADJUSTMENTS TO PROVIDER	.02	8/27/2010	15,444		
		ADJUSTMENTS TO PROVIDER	.03				
		ADJUSTMENTS TO PROVIDER	.04				
		ADJUSTMENTS TO PROVIDER	.05				
		ADJUSTMENTS TO PROGRAM	.50				
		ADJUSTMENTS TO PROGRAM	.51				
		ADJUSTMENTS TO PROGRAM	.52				
		ADJUSTMENTS TO PROGRAM	.53				
		ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL		.99		88,902		NONE
4	TOTAL INTERIM PAYMENTS				1,213,122		
	TO BE COMPLETED BY INTERMEDIARY						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
		TENTATIVE TO PROVIDER	.01				
		TENTATIVE TO PROVIDER	.02				
		TENTATIVE TO PROVIDER	.03				
		TENTATIVE TO PROGRAM	.50				
		TENTATIVE TO PROGRAM	.51				
		TENTATIVE TO PROGRAM	.52				
	SUBTOTAL		.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01				
		SETTLEMENT TO PROGRAM	.02		130,657		
7	TOTAL MEDICARE PROGRAM LIABILITY				1,082,465		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011
COMPONENT NO: 14-Z300 | WORKSHEET E-2

TITLE XVIII SWING BED SNF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	935,728	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	171,159	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	902	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,106,887	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,106,887	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,106,887	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	24,422	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,082,465	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,082,465	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,213,122	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-130,657	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 2/14/2011
14-1300	FROM 9/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 8/31/2010	PART II
14-1300		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT

HOSPITAL

1	INPATIENT SERVICES	875,662
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	875,662
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	884,419
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	884,419
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	178,527
21	EXCESS REASONABLE COST	
22	SUBTOTAL	705,892
23	COINSURANCE	
24	SUBTOTAL	705,892
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	33,229
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	33,229
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	26,711
26	SUBTOTAL	739,121
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	739,121
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	803,302
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-64,181
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

BALANCE SHEET | PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	271,627			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	2,773,255			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,338,606			
7	INVENTORY	29,629			
8	PREPAID EXPENSES	113,847			
9	OTHER CURRENT ASSETS	350,000			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	2,199,752			
	FIXED ASSETS				
12	LAND	70,514			
12.01					
13	LAND IMPROVEMENTS	36,143			
13.01	LESS ACCUMULATED DEPRECIATION	-36,143			
14	BUILDINGS	2,431,351			
14.01	LESS ACCUMULATED DEPRECIATION	-2,157,442			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	84,028			
16.01	LESS ACCUMULATED DEPRECIATION	-80,593			
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	1,571,718			
18.01	LESS ACCUMULATED DEPRECIATION	-1,426,724			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	492,852			
	OTHER ASSETS				
22	INVESTMENTS	29,297			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	83,259			
26	TOTAL OTHER ASSETS	112,556			
27	TOTAL ASSETS	2,805,160			

BALANCE SHEET | PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET G

	LIABILITIES AND FUND BALANCE	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	950,152			
29	SALARIES, WAGES & FEES PAYABLE	515,720			
30	PAYROLL TAXES PAYABLE	68,767			
31	NOTES AND LOANS PAYABLE (SHORT TERM)	535,382			
32	DEFERRED INCOME	22,044			
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES				
36	TOTAL CURRENT LIABILITIES	2,092,065			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE				
38	NOTES PAYABLE	702,534			
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES	702,534			
43	TOTAL LIABILITIES	2,794,599			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	10,561			
45	SPECIFIC PURPOSE FUND				
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49	PLANT FUND BALANCE-INVESTED IN PLANT				
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51	TOTAL FUND BALANCES	10,561			
52	TOTAL LIABILITIES AND FUND BALANCES	2,805,160			

STATEMENT OF CHANGES IN FUND BALANCES | PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET G-1

		GENERAL FUND	SPECIFIC PURPOSE FUND
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD	-1,625,270	
2	NET INCOME (LOSS)	1,635,831	
3	TOTAL	10,561	
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
4	ADDITIONS (CREDIT ADJUSTM		
5			
6			
7			
8			
9			
10	TOTAL ADDITIONS		
11	SUBTOTAL	10,561	
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
12	DEDUCTIONS (DEBIT ADJUSTM		
13			
14			
15			
16			
17			
18	TOTAL DEDUCTIONS		
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	10,561	

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET G-2 | PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL
			1	2	3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	837,302		837,302
2	00	SUBPROVIDER			
4	00	SWING BED - SNF	422,227		422,227
5	00	SWING BED - NF	199,955		199,955
7	00	NURSING FACILITY			
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	1,459,484		1,459,484
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	1,459,484		1,459,484
17	00	ANCILLARY SERVICES	1,674,485	7,481,942	9,156,427
18	00	OUTPATIENT SERVICES		2,789,885	2,789,885
18	50	RURAL HEALTH CLINIC		126,886	126,886
18	51	RURAL HEALTH CLINIC 2		479,808	479,808
18	52	RURAL HEALTH CLINIC 3		258,899	258,899
18	53	RURAL HEALTH CLINIC 4		149,906	149,906
20	00	AMBULANCE SERVICES		999,911	999,911
22	00	AMBULATORY SURGICAL CENTER (D.P.)			
24	00				
25	00	TOTAL PATIENT REVENUES	3,133,969	12,287,237	15,421,206

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES	8,916,715
		ADD (SPECIFY)	
27	00	ADD (SPECIFY)	
28	00		
29	00		
30	00		
31	00		
32	00		
33	00	TOTAL ADDITIONS	
		DEDUCT (SPECIFY)	
34	00	DEDUCT (SPECIFY)	
35	00		
36	00		
37	00		
38	00		
39	00	TOTAL DEDUCTIONS	
40	00	TOTAL OPERATING EXPENSES	8,916,715

STATEMENT OF REVENUES AND EXPENSES | PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	15,421,206
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	4,742,352
3	NET PATIENT REVENUES	10,678,854
4	LESS: TOTAL OPERATING EXPENSES	8,916,715
5	NET INCOME FROM SERVICE TO PATIENTS	1,762,139
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	138,301
7	INCOME FROM INVESTMENTS	7,763
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	54,796
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	3,662
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS,FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	5,757
23	GOVERNMENTAL APPROPRIATIONS	319,024
24	MISCELLANEOUS INCOME	13,989
24.01	GAIN FROM SALE OF FARM LAND	594,710
24.02	FUNDRAISING, NET	8,455
24.03	WELLNESS CENTER	5,687
24.04	HEALTH FAIR	16,149
24.05	UNREALIZED INVESTMENT GAINS	2,061
25	TOTAL OTHER INCOME	1,170,354
26	TOTAL	2,932,493
	OTHER EXPENSES	
27	FARM EXPENSES	2,336
28	BAD DEBT EXPENSE	1,294,326
29		
30	TOTAL OTHER EXPENSES	1,296,662
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,635,831

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

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-1
COMPONENT NO: 14-3403

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	5,720	471	6,191	
2	PHYSICIAN ASSISTANT				
3	NURSE PRACTITIONER	76,885	6,327	83,212	
4	VISITING NURSE				
5	OTHER NURSE	4,922	405	5,327	
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS	21,335	1,756	23,091	
10	SUBTOTAL (SUM OF LINES 1-9)	108,862	8,959	117,821	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		11,740	11,740	
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)		11,740	11,740	
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		3,494	3,494	
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS		2,873	2,873	
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		6,367	6,367	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	108,862	27,066	135,928	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS				
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)				
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	108,862	27,066	135,928	

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

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-1

COMPONENT NO: 14-3403

RHC 1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	6,191		6,191
2	PHYSICIAN ASSISTANT			
3	NURSE PRACTITIONER	83,212		83,212
4	VISITING NURSE			
5	OTHER NURSE	5,327		5,327
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS	23,091		23,091
10	SUBTOTAL (SUM OF LINES 1-9)	117,821		117,821
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT	11,740		11,740
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)	11,740		11,740
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	3,494		3,494
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS	2,873		2,873
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	6,367		6,367
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	135,928		135,928
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS			
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)			
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	135,928		135,928

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

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-1

COMPONENT NO: 14-3475

RHC 2

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN				
2	PHYSICIAN ASSISTANT	147,597	7,029	154,626	
3	NURSE PRACTITIONER	74,984	3,571	78,555	
4	VISITING NURSE				
5	OTHER NURSE	68,838	3,278	72,116	
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS	27,190	1,295	28,485	
10	SUBTOTAL (SUM OF LINES 1-9)	318,609	15,173	333,782	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		1,600	1,600	
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)		1,600	1,600	
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		7,129	7,129	
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS		714	714	
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		7,843	7,843	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	318,609	24,616	343,225	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS				
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)				
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	318,609	24,616	343,225	

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

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-1

COMPONENT NO: 14-3475

RHC 2

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN			
2	PHYSICIAN ASSISTANT	154,626		154,626
3	NURSE PRACTITIONER	78,555		78,555
4	VISITING NURSE			
5	OTHER NURSE	72,116		72,116
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS	28,485		28,485
10	SUBTOTAL (SUM OF LINES 1-9)	333,782		333,782
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT	1,600		1,600
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)	1,600		1,600
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	7,129		7,129
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS	714		714
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	7,843		7,843
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	343,225		343,225
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS			
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)			
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	343,225		343,225

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

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-1

COMPONENT NO: 14-3474

RHC 3

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	177,211	22,624	199,835	
2	PHYSICIAN ASSISTANT	6,364	812	7,176	
3	NURSE PRACTITIONER				
4	VISITING NURSE				
5	OTHER NURSE	33,742	4,308	38,050	
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS	919	117	1,036	
10	SUBTOTAL (SUM OF LINES 1-9)	218,236	27,861	246,097	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT				
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)				
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		6,654	6,654	
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS		5,729	5,729	
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		12,383	12,383	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	218,236	40,244	258,480	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS		3,600	3,600	
30	ADMINISTRATIVE COSTS				
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		3,600	3,600	
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	218,236	43,844	262,080	

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

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 8/31/2010	
14-3474		

RHC 3

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	199,835		199,835
2	PHYSICIAN ASSISTANT	7,176		7,176
3	NURSE PRACTITIONER			
4	VISITING NURSE			
5	OTHER NURSE	38,050		38,050
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS	1,036		1,036
10	SUBTOTAL (SUM OF LINES 1-9)	246,097		246,097
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	6,654		6,654
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS	5,729		5,729
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	12,383		12,383
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	258,480		258,480
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS	3,600		3,600
30	ADMINISTRATIVE COSTS			
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	3,600		3,600
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	262,080		262,080

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

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-1

COMPONENT NO: 14-3476

RHC 4

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	82,829	21,045	103,874	
2	PHYSICIAN ASSISTANT				
3	NURSE PRACTITIONER	11,079	2,815	13,894	
4	VISITING NURSE				
5	OTHER NURSE	45,034	11,442	56,476	
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS	15,097	3,836	18,933	
10	SUBTOTAL (SUM OF LINES 1-9)	154,039	39,138	193,177	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		12,517	12,517	
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)		12,517	12,517	
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		2,899	2,899	
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS		6,580	6,580	
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		9,479	9,479	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	154,039	61,134	215,173	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS				
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)				
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	154,039	61,134	215,173	

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

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 8/31/2010	
14-3476		

RHC 4

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	103,874		103,874
2	PHYSICIAN ASSISTANT			
3	NURSE PRACTITIONER	13,894		13,894
4	VISITING NURSE			
5	OTHER NURSE	56,476		56,476
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS	18,933		18,933
10	SUBTOTAL (SUM OF LINES 1-9)	193,177		193,177
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT	12,517		12,517
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)	12,517		12,517
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	2,899		2,899
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS	6,580		6,580
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	9,479		9,479
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	215,173		215,173
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS			
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)			
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	215,173		215,173

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-2

COMPONENT NO: 14-3403

RHC 1

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	.04		4,200	168
2	PHYSICIAN ASSISTANTS			2,100	
3	NURSE PRACTITIONERS	.97	1,720	2,100	2,037
4	SUBTOTAL (SUM OF LINES 1-3)	1.01	1,720		2,205
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.01	1,720		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	135,928
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	135,928
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	54,150
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	54,150
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	54,150
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	54,150
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	190,078

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	2,205
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2,205
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-2

COMPONENT NO: 14-3475

RHC 2

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS			4,200	
2	PHYSICIAN ASSISTANTS	1.79	3,929	2,100	3,759
3	NURSE PRACTITIONERS	.94	2,064	2,100	1,974
4	SUBTOTAL (SUM OF LINES 1-3)	2.73	5,993		5,733
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.73	5,993		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	343,225
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	343,225
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	157,863
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	157,863
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	157,863
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	157,863
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	501,088

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	5,993
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	5,993
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-2

COMPONENT NO: 14-3474

RHC 3

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	1.12	3,216	4,200	4,704
2	PHYSICIAN ASSISTANTS	.13	199	2,100	273
3	NURSE PRACTITIONERS			2,100	
4	SUBTOTAL (SUM OF LINES 1-3)	1.25	3,415		4,977
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.25	3,415		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	258,480
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	258,480
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	3,600
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	96,359
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	99,959
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	99,959
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	99,959
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	358,439

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	4,977
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	4,977
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-2

COMPONENT NO: 14-3476

RHC 4

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	.42	1,364	4,200	1,764
2	PHYSICIAN ASSISTANTS			2,100	
3	NURSE PRACTITIONERS	.18	512	2,100	378
4	SUBTOTAL (SUM OF LINES 1-3)	.60	1,876		2,142
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	.60	1,876		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	215,173
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	215,173
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	76,338
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	76,338
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	76,338
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	76,338
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	291,511

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	2,142
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2,142
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-3
COMPONENT NO: 14-3403

TITLE XVIII RHC 1

	DETERMINATION OF RATE FOR RHC/FQHC SERVICES		
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	190,078	
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	2,029	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	188,049	
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	2,205	
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)		
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,205	
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	85.28	
		CALCULATION OF LIMIT (1)	
		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	85.28	85.28
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		253
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		21,576
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		21,576
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		4,561
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		17,015
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		13,612
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		1,354
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		14,966
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		14,966
25	INTERIM PAYMENTS		12,235
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		2,731
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-3
COMPONENT NO: 14-3475

TITLE XVIII RHC 2

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

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	501,088
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	2,108
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	498,980
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	5,993
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,993
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	83.26

CALCULATION OF LIMIT (1)

		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	83.26	83.26
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		522
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		43,462
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		43,462
16.01	PRIMARY PAYER AMOUNT		36
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		6,631
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		36,795
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		29,436
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		502
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		29,938
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		29,938
25	INTERIM PAYMENTS		26,165
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		3,773
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-3
COMPONENT NO: 14-3474

TITLE XVIII RHC 3

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

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	358,439
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	5,661
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	352,778
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	4,977
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,977
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	70.88

CALCULATION OF LIMIT (1)

		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	70.88	70.88
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		1,045
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		74,070
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		74,070
16.01	PRIMARY PAYER AMOUNT		127
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		13,686
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		60,257
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		48,206
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		3,657
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		51,863
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		51,863
25	INTERIM PAYMENTS		45,088
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		6,775
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-3
COMPONENT NO: 14-3476

TITLE XVIII RHC 4

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

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	291,511
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	2,032
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	289,479
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	2,142
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,142
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	135.14

CALCULATION OF LIMIT (1)

		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	135.14	135.14
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		635
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		85,814
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		85,814
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		10,480
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		75,334
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		60,267
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		1,133
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		61,400
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		61,400
25	INTERIM PAYMENTS		25,616
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		35,784
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

PROVIDER NO: 14-1300 | PERIOD: FROM 9/ 1/2009 TO 8/31/2010 | PREPARED 2/14/2011 | WORKSHEET M-4

COMPONENT NO: 14-3403

TITLE XVIII RHC 1

		PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1	HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	117,821	117,821	117,821	117,821
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000763	.004298		
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	90	506		
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	23	832		
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	113	1,338		
6	TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	135,928	135,928	135,928	135,928
7	TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	54,150	54,150	54,150	54,150
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000831	.009843		
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	45	533		
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	158	1,871		
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	2	72		
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	79.00	25.99		
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	2	46		
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	158	1,196		
15	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)		2,029		
16	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 20)		1,354		

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	WORKSHEET M-4
COMPONENT NO:	TO 8/31/2010	
14-3475		

TITLE XVIII RHC 2

		PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1	HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	333,782	333,782	333,782	333,782
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000020	.000773		
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	7	258		
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	12	1,167		
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	19	1,425		
6	TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	343,225	343,225	343,225	343,225
7	TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	157,863	157,863	157,863	157,863
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000055	.004152		
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	9	655		
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	28	2,080		
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	1	101		
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	28.00	20.59		
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	1	23		
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	28	474		
15	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)		2,108		
16	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 20)		502		

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	WORKSHEET M-4
COMPONENT NO:	TO 8/31/2010	
14-3474		

TITLE XVIII RHC 3

		PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1	HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	246,097	246,097	246,097	246,097
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000649	.008551	.000020	
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	160	2,104	5	
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	219	1,594		
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	379	3,698	5	
6	TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	258,480	258,480	258,480	258,480
7	TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	99,959	99,959	99,959	99,959
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.001466	.014307	.000019	
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	147	1,430	2	
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	526	5,128	7	
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	19	138	1	
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	27.68	37.16	7.00	
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	18	85		
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	498	3,159		
15	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)		5,661		
16	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 20)		3,657		

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	WORKSHEET M-4
COMPONENT NO:	TO 8/31/2010	
14-3476		

TITLE XVIII RHC 4

		PNEUMOCOCCAL 1	INFLUENZA 2	H1N1 ONLY 2. 1	INFLUENZA AND H1N1 2. 2
1	HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	193,177	193,177	193,177	193,177
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000020	.003839	.000020	
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	4	742	4	
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	69	681		
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	73	1,423	4	
6	TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	215,173	215,173	215,173	215,173
7	TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	76,338	76,338	76,338	76,338
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.000339	.006613	.000019	
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	26	505	1	
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	99	1,928	5	
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	6	59	4	
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	16.50	32.68	1.25	
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	1	34	4	
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	17	1,111	5	
15	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)		2,032		
16	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 20)		1,133		

	PROVIDER NO: 14-1300	PERIOD: FROM 9/ 1/2009	PREPARED 2/14/2011
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	COMPONENT NO: 14-3403	TO 8/31/2010	WORKSHEET M-5

[X] RHC [ ] FQHC

RHC 1

	DESCRIPTION		PART B MM/DD/YYYY 1	PART B AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			12,235
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	ADJUSTMENTS TO PROVIDER	.01		
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		NONE
4	TOTAL INTERIM PAYMENTS			12,235
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02		2,731
7	TOTAL MEDICARE PROGRAM LIABILITY			14,966

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

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

[X] RHC [ ] FQHC

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	WORKSHEET M-5
COMPONENT NO: 14-3475	TO 8/31/2010	

RHC 2

	DESCRIPTION		PART B MM/DD/YYYY 1	PART B AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			21,786
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	ADJUSTMENTS TO PROVIDER	.01	3/ 5/2010	4,379
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		4,379
4	TOTAL INTERIM PAYMENTS			26,165
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02		3,773
7	TOTAL MEDICARE PROGRAM LIABILITY			29,938

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

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

[X] RHC [ ] FQHC

PROVIDER NO:	PERIOD:	PREPARED
14-1300	FROM 9/ 1/2009	WORKSHEET M-5
COMPONENT NO: 14-3474	TO 8/31/2010	

RHC 3

	DESCRIPTION		PART B MM/DD/YYYY 1	AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			41,055
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	ADJUSTMENTS TO PROVIDER	.01	3/ 5/2010	4,033
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		4,033
4	TOTAL INTERIM PAYMENTS			45,088
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02		6,775
7	TOTAL MEDICARE PROGRAM LIABILITY			51,863

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO: 14-1300	PERIOD: FROM 9/ 1/2009	PREPARED 2/14/2011
[X] RHC [ ] FQHC	COMPONENT NO: 14-3476	TO 8/31/2010	WORKSHEET M-5

RHC 4

	DESCRIPTION		PART B MM/DD/YYYY (1)	PART B AMOUNT (2)
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			27,084
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	ADJUSTMENTS TO PROVIDER	.01		
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50	3/ 5/2010	1,468
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		-1,468
4	TOTAL INTERIM PAYMENTS			25,616
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02		35,784
7	TOTAL MEDICARE PROGRAM LIABILITY			61,400

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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