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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S Parts I-III Date/Time Prepared: 2/8/2012 10:44 am

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 2/8/2012 Time: 10:44 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 for the cost reporting period beginning 09/01/2010 and ending 08/31/2011 and 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 identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	22,040	616,783	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	131,400	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	Skilled Nursing Facility	0	0	0		0	7.00
8.00	Nursing Facility	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		14,330		0	10.00
10.01	RURAL HEALTH CLINIC II II	0		5,820		0	10.01
10.02	RURAL HEALTH CLINIC III III	0		20,402		0	10.02
10.03	RURAL HEALTH CLINIC IV IV	0		8,191		0	10.03
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	153,440	665,526	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 2/7/2012 3:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 SCHOOL STREET	PO Box:			1.00
2.00	City: CARROLLTON	State: IL	Zip Code: 62016	County: GREENE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	THOMAS H BOYD CRITICAL ACC HOSPITAL	141300	99914	1	07/12/1999	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	THOMAS H BOYD CRITICAL ACC SWING BED	14Z300	99914		07/12/1999	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF						N		N	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC						N	N	N	13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GREENE COUNTY RHC	143403	99914		06/22/1995	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1	T.H. BOYD RHC	143475	99914		10/02/2005	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC 2	BOYD-FILLAGER GREENFIELD RHC	143474	99914		10/03/2005	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC 3	RHC OF ROODHOUSE	143476	99914		10/04/2005	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2010	08/31/2011	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0	25.00

		1.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.	2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0	35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet S-2 Part I Date/Time Prepared: 2/7/2012 3:39 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

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

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

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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 2/7/2012 3:39 pm

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N	80.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet S-2 Part I Date/Time Prepared: 2/7/2012 3:39 pm

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

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

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

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	0	0	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet S-2 Part I Date/Time Prepared: 2/7/2012 3:39 pm

		1.00	2.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 2/7/2012 3:39 pm

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

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

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

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	01/04/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 2/7/2012 3:39 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 2/7/2012 3:39 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/04/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-3 Part I Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	20,364.37		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	20,364.37		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	20,364.37		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	40.00	0	0			16.00
17.00	SUBPROVIDER - IRF	41.00	0	0			17.00
18.00	SUBPROVIDER	42.00	0	0			18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	45.00	0	0			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10					25.10
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.01	RURAL HEALTH CLINIC II	88.01					26.01
26.02	RURAL HEALTH CLINIC III	88.02					26.02
26.03	RURAL HEALTH CLINIC IV	88.03					26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF	40.00					28.01
28.02	SUBPROVIDER - IRF	41.00					28.02
28.03	SUBPROVIDER	42.00					28.03
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	743	33	911		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	632	0	632		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	939		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,375	33	2,482		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0	1,375	33	2,482		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	0	0	0		16.00
17.00	SUBPROVIDER - IRF	0	0	0	0		17.00
18.00	SUBPROVIDER	0	0	0	0		18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0		0	0		20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0		25.10
26.00	RURAL HEALTH CLINIC	0	0	0	1,635		26.00
26.01	RURAL HEALTH CLINIC II	0	0	0	6,034		26.01
26.02	RURAL HEALTH CLINIC III	0	0	0	3,381		26.02
26.03	RURAL HEALTH CLINIC IV	0	0	0	1,912		26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		53	342		28.00
28.01	SUBPROVIDER - IPF	0	0	0	0		28.01
28.02	SUBPROVIDER - IRF	0	0	0	0		28.02
28.03	SUBPROVIDER	0	0	0	0		28.03
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	279	1.00
2.00	HMO					0	2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	158.00	0.00	0	279	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0.00	0.00	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00	SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0.00	0.00	0.00			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00	0.00	0.00			23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00	0.00	0.00			25.10
26.00	RURAL HEALTH CLINIC	0.00	0.92	0.00			26.00
26.01	RURAL HEALTH CLINIC II	0.00	2.41	0.00			26.01
26.02	RURAL HEALTH CLINIC III	0.00	1.11	0.00			26.02
26.03	RURAL HEALTH CLINIC IV	0.00	0.62	0.00			26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00	Total (sum of lines 14-26)	0.00	163.06	0.00			27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF						28.01
28.02	SUBPROVIDER - IRF						28.02
28.03	SUBPROVIDER						28.03
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	19	361		1.00
2.00	HMO				2.00
3.00	HMO IPF				3.00
4.00	HMO IRF				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				5.00
6.00	Hospital Adults & Peds. Swing Bed NF				6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00	INTENSIVE CARE UNIT				8.00
9.00	CORONARY CARE UNIT				9.00
10.00	BURN INTENSIVE CARE UNIT				10.00
11.00	SURGICAL INTENSIVE CARE UNIT				11.00
12.00	OTHER SPECIAL CARE (SPECIFY)				12.00
13.00	NURSERY				13.00
14.00	Total (see instructions)	19	361		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF	0	0		16.00
17.00	SUBPROVIDER - IRF	0	0		17.00
18.00	SUBPROVIDER	0	0		18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
25.10	CMHC - CORF				25.10
26.00	RURAL HEALTH CLINIC				26.00
26.01	RURAL HEALTH CLINIC II				26.01
26.02	RURAL HEALTH CLINIC III				26.02
26.03	RURAL HEALTH CLINIC IV				26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
28.01	SUBPROVIDER - IPF				28.01
28.02	SUBPROVIDER - IRF				28.02
28.03	SUBPROVIDER				28.03
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

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

Provider CCN: 141300 Component CCN: 143403 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-8 | Date/Time Prepared: 2/7/2012 3:39 pm

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			505 S. MAIN		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	WHITE HALL		IL	62092	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic			08:00	17:00	11.00
				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	Provider name, CCN number					14.00
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)	N	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143403	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) I	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	GREENE					2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143403	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) I	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143403	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) I	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic				11.00

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

Provider CCN: 141300 Component CCN: 143475

Period: From 09/01/2010 To 08/31/2011

Worksheet S-8

Date/Time Prepared: 2/7/2012 3:39 pm

				Rural Health Clinic (RHC) II	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			800 SCHOOL STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	CARROLLTON		IL	62016	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic	08:00	18:00	09:00	18:00	11.00
				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	Provider name, CCN number					14.00
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143475	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) II	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	GREENE					2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	18:00	09:00	18:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143475	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) II	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	18:00	09:00	18:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143475	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) II	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	08:00	18:00		11.00

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

Provider CCN: 141300 Component CCN: 143474

Period: From 09/01/2010 To 08/31/2011

Worksheet S-8

Date/Time Prepared: 2/7/2012 3:39 pm

		Rural Health Clinic (RHC) III	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	712 COLLEGE STREET	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	GREENFIELD	IL	62044	2.00

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

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

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

		Sunday		Monday			
		from	to	from	to		
		1.00	2.00	3.00	4.00		
	Facility hours of operations (1)						
11.00	Clinic			09:00	12:00		11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

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

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143474	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) III	Cost

			County					
			4.00					
2.00	City, State, Zip Code, County		GREENE					2.00
		Tuesday		Wednesday				
		from	to	from	to			
		5.00	6.00	7.00	8.00			
	Facility hours of operations (1)							
11.00	Clinic	09:00	12:00	09:00	12:00			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143474	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) III	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	12:00	09:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143474	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) III	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic				11.00

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

Provider CCN: 141300 Component CCN: 143476 | Period: From 09/01/2010 To 08/31/2011 | Worksheet S-8 | Date/Time Prepared: 2/7/2012 3:39 pm

				Rural Health Clinic (RHC) IV	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			132 W. LORTON		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	ROODHOUSE		IL	62082	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic			08:00	12:00	11.00
				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	Provider name, CCN number					14.00
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)	N	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143476	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) IV	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	GREENE					2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00	08:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143476	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) IV	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00	08:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143476	Period: From 09/01/2010 To 08/31/2011	Worksheet S-8 Date/Time Prepared: 2/7/2012 3:39 pm
		Rural Health Clinic (RHC) IV	Cost

		Saturday		
		from	to	
		13.00	14.00	
	Facility hours of operations (1)			
11.00	Clinic			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet S-10 Date/Time Prepared: 2/7/2012 3:39 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.630747	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	231,145	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	1,338,500	6.00
7.00	Medicaid cost (line 1 times line 6)	844,255	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	613,110	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	613,110	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	251,074	93,938	345,012	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	158,364	59,251	217,615	21.00
22.00	Partial payment by patients approved for charity care	160,648	20,923	181,571	22.00
23.00	Cost of charity care (line 21 minus line 22)	-2,284	38,328	36,044	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,145,276	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	155,486	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	989,790	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	624,307	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	660,351	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,273,461	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT		134,576	134,576	-61,285	73,291	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.		0	0	13,399	13,399	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP		0	0	322,776	322,776	2.00
3.00	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	EMPLOYEE BENEFITS	0	709,164	709,164	113,123	822,287	4.00
5.00	ADMINISTRATIVE & GENERAL	682,507	713,728	1,396,235	133,677	1,529,912	5.00
7.00	OPERATION OF PLANT	57,583	194,021	251,604	-54,953	196,651	7.00
8.00	LAUNDRY & LINEN SERVICE	18,816	10,191	29,007	0	29,007	8.00
9.00	HOUSEKEEPING	69,027	35,833	104,860	7,396	112,256	9.00
10.00	DIETARY	148,773	71,355	220,128	0	220,128	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	36,095	4,820	40,915	-40,915	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	20,901	79,179	100,080	0	100,080	14.00
15.00	PHARMACY	0	297,742	297,742	0	297,742	15.00
16.00	MEDICAL RECORDS & LIBRARY	85,572	9,579	95,151	0	95,151	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,215,671	175,972	1,391,643	-35,869	1,355,774	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	341,719	384,188	725,907	-174,736	551,171	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	295,659	316,989	612,648	-56,137	556,511	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	29,691	29,691	2,571	32,262	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	173,171	33,801	206,972	0	206,972	66.00
69.00	ELECTROCARDIOLOGY	0	41,461	41,461	14,214	55,675	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	158,384	42,785	201,169	-35,865	165,304	88.00
88.01	RURAL HEALTH CLINIC II	355,475	53,000	408,475	-32,868	375,607	88.01
88.02	RURAL HEALTH CLINIC III	257,265	39,699	296,964	-48,600	248,364	88.02
88.03	RURAL HEALTH CLINIC IV	195,300	49,993	245,293	-12,964	232,329	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	5,014	546	5,560	0	5,560	90.00
91.00	EMERGENCY	1,236,195	147,211	1,383,406	341,127	1,724,533	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	429,570	129,347	558,917	-314,299	244,618	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE		0	0	-82,607	-82,607	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,782,697	3,704,871	9,487,568	-2,815	9,484,753	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	0	0	0	0	0	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	39,595	1,315	40,910	2,815	43,725	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
200.00	TOTAL (SUM OF LINES 118-199)	5,822,292	3,706,186	9,528,478	0	9,528,478	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-12,227	61,064		1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	13,399		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-748	322,028		2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	EMPLOYEE BENEFITS	-17,471	804,816		4.00
5.00	ADMINISTRATIVE & GENERAL	-129,675	1,400,237		5.00
7.00	OPERATION OF PLANT	0	196,651		7.00
8.00	LAUNDRY & LINEN SERVICE	0	29,007		8.00
9.00	HOUSEKEEPING	0	112,256		9.00
10.00	DIETARY	-42,646	177,482		10.00
11.00	CAFETERIA	0	0		11.00
13.00	NURSING ADMINISTRATION	0	0		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	100,080		14.00
15.00	PHARMACY	0	297,742		15.00
16.00	MEDICAL RECORDS & LIBRARY	-5,332	89,819		16.00
23.00	PARAMED ED PRGM	0	0		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-32	1,355,742		30.00
40.00	SUBPROVIDER - IPF	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0		41.00
42.00	SUBPROVIDER	0	0		42.00
45.00	NURSING FACILITY	0	0		45.00
	ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	-190	550,981		54.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0		59.00
60.00	LABORATORY	-40	556,471		60.00
60.01	BLOOD LABORATORY	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	32,262		63.00
64.00	INTRAVENOUS THERAPY	0	0		64.00
66.00	PHYSICAL THERAPY	-27,332	179,640		66.00
69.00	ELECTROCARDIOLOGY	-41,461	14,214		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	165,304		88.00
88.01	RURAL HEALTH CLINIC II	0	375,607		88.01
88.02	RURAL HEALTH CLINIC III	0	248,364		88.02
88.03	RURAL HEALTH CLINIC IV	0	232,329		88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	5,560		90.00
91.00	EMERGENCY	-127,792	1,596,741		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	-244,617	1		95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
99.10	CORF	0	0		99.10
	SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0		110.00
111.00	ISLET ACQUISITION	0	0		111.00
113.00	INTEREST EXPENSE	82,607	0		113.00
114.00	UTILIZATION REVIEW-SNF	0	0		114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0		117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-566,956	8,917,797		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	RESEARCH	0	0		191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	JAIL MEALS	0	0		192.01
192.02	OUTPATIENT MEALS	0	0		192.02
192.03	IDLE SPACE	0	0		192.03
193.00	NONPAID WORKERS	0	0		193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	43,725		194.00
200.00	TOTAL (SUM OF LINES 118-199)	-566,956	8,961,522		200.00

RECLASSIFICATIONS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-6 | Date/Time Prepared: 2/7/2012 3:39 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	3,767		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	56,154		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	0	2,000		3.00
	TOTALS		0	61,921		
	B - RECLASS INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	9,248		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	73,359		2.00
	TOTALS		0	82,607		
	C - RECLASS SALARIES TO EKG COST CENTER					
1.00	ELECTROCARDIOLOGY	69.00	13,204	1,010		1.00
2.00		0.00	0	0		2.00
	TOTALS		13,204	1,010		
	D - RECLASS RHC INSURANCE ACCOUNTS					
1.00	EMPLOYEE BENEFITS	4.00	0	102,867		1.00
2.00	RURAL HEALTH CLINIC IV	88.03	0	27,601		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	9,118		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	2,520		4.00
5.00	RURAL HEALTH CLINIC II	88.01	0	7,560		5.00
6.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	636		6.00
	TOTALS		0	150,302		
	E - NURSING ADMIN SALARY AND BENEFITS					
1.00	EMERGENCY	91.00	36,095	4,820		1.00
	TOTALS		36,095	4,820		
	F - RECLASS RHC ADMIN COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	18,241		1.00
2.00	OPERATION OF PLANT	7.00	0	5,705		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	23,946		
	G - RHC BUSINESS OFFICE AND HOUSEKEEPING					
1.00	ADMINISTRATIVE & GENERAL	5.00	156,767	0		1.00
2.00	HOUSEKEEPING	9.00	7,396	0		2.00
3.00	EMPLOYEE BENEFITS	4.00	0	9,699		3.00
4.00		0.00	0	0		4.00
	TOTALS		164,163	9,699		
	H - RHC LAB TIME					
1.00	LABORATORY	60.00	7,417	0		1.00
2.00	EMPLOYEE BENEFITS	4.00	0	557		2.00
3.00	BLOOD STORING, PROCESSING & TRANS.	63.00	2,400	171		3.00
4.00		0.00	0	0		4.00
	TOTALS		9,817	728		
	I - RECLASSIFY ER ADMIN TIME					
1.00	ADMINISTRATIVE & GENERAL	5.00	47,725	2,190		1.00
	TOTALS		47,725	2,190		
	J - RECLASS LEASES TO CAPITAL					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	257,374		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	257,374		
	K - RECLASS ER SALARIES AND BENEFITS					
1.00	EMERGENCY	91.00	344,086	30,871		1.00
	TOTALS		344,086	30,871		
	L - ER PHYS. SAL TO RHC CARROLLTON					
1.00	RURAL HEALTH CLINIC II	88.01	19,864	4,966		1.00
	TOTALS		19,864	4,966		
	M - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	9,632		1.00
2.00	RURAL HEALTH CLINIC IV	88.03	0	1,856		2.00
3.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	2,815		3.00
	TOTALS		0	14,303		
	N - AMBULANCE COSTS IN OP OF PLANT					
1.00	AMBULANCE SERVICES	95.00	0	60,658		1.00
	TOTALS		0	60,658		
500.00	Grand Total: Increases		634,954	705,395		500.00

RECLASSIFICATIONS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-6 | Date/Time Prepared: 2/7/2012 3:39 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	61,921	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	61,921			
	B - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	82,607	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	82,607			
	C - RECLASS SALARIES TO EKG COST CENTER						
1.00	ADULTS & PEDIATRICS	30.00	6,556	502	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	6,648	508	0		2.00
	TOTALS		13,204	1,010			
	D - RECLASS RHC INSURANCE ACCOUNTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	150,302	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	12		6.00
	TOTALS		0	150,302			
	E - NURSING ADMIN SALARY AND BENEFITS						
1.00	NURSING ADMINISTRATION	13.00	36,095	4,820	0		1.00
	TOTALS		36,095	4,820			
	F - RECLASS RHC ADMIN COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	6,377	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	7,721	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	4,462	0		3.00
4.00	RURAL HEALTH CLINIC IV	88.03	0	5,386	0		4.00
	TOTALS		0	23,946			
	G - RHC BUSINESS OFFICE AND HOUSEKEEPING						
1.00	RURAL HEALTH CLINIC	88.00	27,956	1,930	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	55,822	1,715	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	47,328	3,219	0		3.00
4.00	RURAL HEALTH CLINIC IV	88.03	33,057	2,835	0		4.00
	TOTALS		164,163	9,699			
	H - RHC LAB TIME						
1.00	RURAL HEALTH CLINIC	88.00	1,985	137	0		1.00
2.00	RURAL HEALTH CLINIC III	88.02	2,537	172	0		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	2,895	248	0		3.00
4.00	LABORATORY	60.00	2,400	171	0		4.00
	TOTALS		9,817	728			
	I - RECLASSIFY ER ADMIN TIME						
1.00	EMERGENCY	91.00	47,725	2,190	0		1.00
	TOTALS		47,725	2,190			
	J - RECLASS LEASES TO CAPITAL						
1.00	LABORATORY	60.00	0	60,983	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	167,580	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	28,811	0		3.00
	TOTALS		0	257,374			
	K - RECLASS ER SALARIES AND BENEFITS						
1.00	AMBULANCE SERVICES	95.00	344,086	30,871	0		1.00
	TOTALS		344,086	30,871			
	L - ER PHYS. SAL TO RHC CARROLLTON						
1.00	EMERGENCY	91.00	19,864	4,966	0		1.00
	TOTALS		19,864	4,966			
	M - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,303	13		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	13		3.00
	TOTALS		0	14,303			
	N - AMBULANCE COSTS IN OP OF PLANT						
1.00	OPERATION OF PLANT	7.00	0	60,658	0		1.00
	TOTALS		0	60,658			
500.00	Grand Total: Decreases		634,954	705,395			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/7/2012 3:39 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	70,514	0	0	0	0	1.00
2.00	Land Improvements	36,143	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,295,222	48,713	0	48,713	0	3.00
4.00	Building Improvements	1,118,449	0	0	0	8,525	4.00
5.00	Fixed Equipment	84,028	0	0	0	0	5.00
6.00	Movable Equipment	1,589,398	133,598	0	133,598	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,193,754	182,311	0	182,311	8,525	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	4,193,754	182,311	0	182,311	8,525	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	106,442	0	0	28,134	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	106,442	0	0	28,134	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,560,516	0	2,560,516	0.586260	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,807,024	0	1,807,024	0.413740	0	2.00
3.00	Total (sum of lines 1-2)	4,367,540	0	4,367,540	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/7/2012 3:39 pm

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	70,514	0	1.00
2.00	Land Improvements	36,143	0	2.00
3.00	Buildings and Fixtures	1,343,935	0	3.00
4.00	Building Improvements	1,109,924	0	4.00
5.00	Fixed Equipment	84,028	0	5.00
6.00	Movable Equipment	1,722,996	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,367,540	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	4,367,540	0	10.00

		SUMMARY OF CAPITAL		
	Cost Center Description	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	134,576	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	134,576	3.00

		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Cost Center Description	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	32,294	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	3,767	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	56,154	257,374	2.00
3.00	Total (sum of lines 1-2)	0	0	0	92,215	257,374	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	28,770	0	0	61,064	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	9,632	0	13,399	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,500	0	0	0	322,028	2.00
3.00	Total (sum of lines 1-2)	8,500	28,770	9,632	0	396,491	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-8 | Date/Time Prepared: 2/7/2012 3:39 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - buildings and fixtures (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)	B	-748	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-1,637	ADMINISTRATIVE & GENERAL	5.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)	A	-1,613	ADMINISTRATIVE & GENERAL	5.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-169,253			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-32,785	DIETARY	10.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-5,332	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00	25.00
26.00	Depreciation - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	INTEREST EXPENSE	A	82,607	INTEREST EXPENSE	113.00	33.00
33.01	ER PHYSICIAN BENEFIT COSTS	A	-16,579	EMPLOYEE BENEFITS	4.00	33.01
34.00	HEALTHLINK FEES	A	32,757	ADMINISTRATIVE & GENERAL	5.00	34.00
36.00	INTREST PAID TO MEDICARE	A	-52,873	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	RENTAL INCOME	B	-12,227	NEW CAP REL COSTS-BLDG & FIXT	1.00	37.00
38.00	AMBULANCE MANAGEMENT FEE	B	-36,000	ADMINISTRATIVE & GENERAL	5.00	38.00
39.00	CARROLLTON RHC MANAGEMENT FEE	B	-6,000	ADMINISTRATIVE & GENERAL	5.00	39.00
40.01	FEES AND PENALTIES	A	-35,512	ADMINISTRATIVE & GENERAL	5.00	40.01
42.00	IHA DUES	A	-1,951	ADMINISTRATIVE & GENERAL	5.00	42.00
44.00	MISC. INC.	B	-892	EMPLOYEE BENEFITS	4.00	44.00
44.01	MISC. INC.	B	-1,172	ADMINISTRATIVE & GENERAL	5.00	44.01
44.02	MISC. INC.	B	-9,861	DIETARY	10.00	44.02
44.03	MISC. INC	B	-32	ADULTS & PEDIATRICS	30.00	44.03
44.04	MISC. INC	B	-190	RADIOLOGY-DIAGNOSTIC	54.00	44.04
44.05	MISC. INC	B	-40	LABORATORY	60.00	44.05
44.06	MISC. INC.	B	-7,801	AMBULANCE SERVICES	95.00	44.06
45.00	AMBULANCE SUBSIDY - OPERATIONS	B	-236,816	AMBULANCE SERVICES	95.00	45.00
45.01	AMBULANCE SUBSIBY - MANAGEMENT	B	-25,674	ADMINISTRATIVE & GENERAL	5.00	45.01
46.00	GREENE COUNTY HEALTH PT COST	A	-27,332	PHYSICAL THERAPY	66.00	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-566,956			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-8 | Date/Time Prepared: 2/7/2012 3:39 pm

		Wkst. A-7 Ref. 5.00				
1.00	Investment income - buildings and fixtures (chapter 2)	11				1.00
2.00	Investment income - movable equipment (chapter 2)	11				2.00
3.00	Investment income - other (chapter 2)	0				3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0				4.00
5.00	Refunds and rebates of expenses (chapter 8)	0				5.00
6.00	Rental of provider space by suppliers (chapter 8)	0				6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0				7.00
8.00	Television and radio service (chapter 21)	0				8.00
9.00	Parking lot (chapter 21)	0				9.00
10.00	Provider-based physician adjustment	0				10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0				11.00
12.00	Related organization transactions (chapter 10)	0				12.00
13.00	Laundry and linen service	0				13.00
14.00	Cafeteria-employees and guests	0				14.00
15.00	Rental of quarters to employee and others	0				15.00
16.00	Sale of medical and surgical supplies to other than patients	0				16.00
17.00	Sale of drugs to other than patients	0				17.00
18.00	Sale of medical records and abstracts	0				18.00
19.00	Nursing school (tuition, fees, books, etc.)	0				19.00
20.00	Vending machines	0				20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0				21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0				22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)					23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)					24.00
25.00	Utilization review - physicians' compensation (chapter 21)					25.00
26.00	Depreciation - buildings and fixtures	0				26.00
27.00	Depreciation - movable equipment	0				27.00
28.00	Non-physician Anesthetist					28.00
29.00	Physicians' assistant	0				29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)					30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)					31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0				32.00
33.00	INTEREST EXPENSE	0				33.00
33.01	ER PHYSICIAN BENEFIT COSTS	0				33.01
34.00	HEALTHLINK FEES	0				34.00
36.00	INTREST PAID TO MEDICARE	0				36.00
37.00	RENTAL INCOME	9				37.00
38.00	AMBULANCE MANAGEMENT FEE	0				38.00
39.00	CARROLLTON RHC MANAGEMENT FEE	0				39.00
40.01	FEES AND PENALTIES	0				40.01
42.00	IHA DUES	0				42.00
44.00	MISC. INC.	0				44.00
44.01	MISC. INC.	0				44.01
44.02	MISC. INC.	0				44.02
44.03	MISC. INC	0				44.03
44.04	MISC. INC	0				44.04
44.05	MISC. INC	0				44.05
44.06	MISC. INC.	0				44.06
45.00	AMBULANCE SUBSIDY - OPERATIONS	0				45.00
45.01	AMBULANCE SUBSIBY - MANAGEMENT	0				45.01
46.00	GREENE COUNTY HEALTH PT COST	0				46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)					50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 2/7/2012 3:39 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	ER PHYSICIANS	879,718	127,792	1.00
2.00		60.00	PATHOLOGY MEDICAL DIRECTOR	5,000	0	2.00
3.00		69.00	EKG/HOLTER FEES	41,461	41,461	3.00
4.00		88.00	MEDICAL DIRECTOR - W/H DR. REID	5,500	0	4.00
5.00		88.00	MEDICAL DIRECTOR - W/H DR. PARCON	6,000	0	5.00
6.00		88.03	MEDICAL DIRECTOR - RH DR. ADAMS	12,000	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00			TOTAL (lines 1.00 through 199.00)	949,679	169,253	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 2/7/2012 3:39 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		751,926	0	0	0	0	1.00
2.00		5,000	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		5,500	0	0	0	0	4.00
5.00		6,000	0	0	0	0	5.00
6.00		12,000	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		780,426		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 2/7/2012 3:39 pm

		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	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 2/7/2012 3:39 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	127,792		1.00
2.00		0	0		2.00
3.00		0	41,461		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	169,253		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet A-8-3 Part Date/Time Prepared: 2/7/2012 3:39 pm
		Occupational Therapy	Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						39	1.00
2.00	Line 1 multiplied by 15 hours per week						585	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						103	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						103	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						0.00	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	190.75	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.50	0.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.75	34.75	0.00				11.00
12.00	Number of travel hours (provider site)	0	68	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						13,257	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						13,257	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						13,257	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						69.50	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						40,658	22.00
23.00	Total salary equivalency (see instructions)						40,658	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						3,579	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						3,579	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						3,579	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						4,726	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						4,726	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						3,579	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						3,579	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet A-8-3 Part Date/Time Prepared: 2/7/2012 3:39 pm
		Occupational Therapy	Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.50	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		40,658	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		40,658	63.00
64.00	Total cost of outside supplier services (from your records)		13,493	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		3,579	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		3,579	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		4,726	101.01
101.02	Line 34 = sum of lines 27 and 31		4,726	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		4,726	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		4,726	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part I Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	61,064	61,064				1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	13,399	0	13,399			1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	322,028			322,028		2.00
4.00	EMPLOYEE BENEFITS	804,816	0	0	0	804,816	4.00
5.00	ADMINISTRATIVE & GENERAL	1,400,237	7,483	1,637	8,181	122,262	5.00
7.00	OPERATION OF PLANT	196,651	2,239	0	1,330	7,946	7.00
8.00	LAUNDRY & LINEN SERVICE	29,007	2,150	0	693	2,597	8.00
9.00	HOUSEKEEPING	112,256	449	0	0	10,546	9.00
10.00	DIETARY	177,482	3,348	0	181	20,530	10.00
11.00	CAFETERIA	0	2,993	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	100,080	1,205	0	0	2,884	14.00
15.00	PHARMACY	297,742	827	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	89,819	1,576	0	290	11,808	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,355,742	19,101	0	32,819	166,849	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	550,981	3,741	0	184,640	46,237	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	556,471	1,981	0	62,871	41,491	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	32,262	0	0	0	331	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	179,640	3,159	0	911	23,896	66.00
69.00	ELECTROCARDIOLOGY	14,214	0	0	0	1,822	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	165,304	0	0	12,833	17,724	88.00
88.01	RURAL HEALTH CLINIC II	375,607	3,220	0	147	44,091	88.01
88.02	RURAL HEALTH CLINIC III	248,364	0	0	0	28,620	88.02
88.03	RURAL HEALTH CLINIC IV	232,329	0	0	12,836	21,989	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	5,560	325	0	0	692	90.00
91.00	EMERGENCY	1,596,741	5,965	0	4,296	215,241	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	1	917	0	0	11,796	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,917,797	60,679	1,637	322,028	799,352	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	0	0	0	0	0	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part I Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	43,725	385	11,762	0	5,464	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	8,961,522	61,064	13,399	322,028	804,816	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part I Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	1,539,800	1,539,800				5.00
7.00	OPERATION OF PLANT	208,166	43,189	251,355			7.00
8.00	LAUNDRY & LINEN SERVICE	34,447	7,147	10,525	52,119		8.00
9.00	HOUSEKEEPING	123,251	25,571	2,197	3,246	154,265	9.00
10.00	DIETARY	201,541	41,814	16,391	80	8,932	10.00
11.00	CAFETERIA	2,993	621	14,653	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	104,169	21,612	5,898	0	0	14.00
15.00	PHARMACY	298,569	61,945	4,047	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	103,493	21,472	7,717	0	1,011	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,574,511	326,667	93,522	34,800	78,523	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	785,599	162,990	18,314	2,351	2,649	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	662,814	137,515	9,696	0	2,565	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	32,593	6,762	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	207,606	43,072	15,465	3,156	1,111	66.00
69.00	ELECTROCARDIOLOGY	16,036	3,327	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	195,861	40,636	0	19	5,765	88.00
88.01	RURAL HEALTH CLINIC II	423,065	87,774	15,763	0	24,398	88.01
88.02	RURAL HEALTH CLINIC III	276,984	57,466	0	57	6,066	88.02
88.03	RURAL HEALTH CLINIC IV	267,154	55,427	0	2	5,765	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	6,577	1,365	1,593	0	0	90.00
91.00	EMERGENCY	1,822,243	378,064	29,201	6,959	14,856	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	12,714	2,638	4,490	1,449	201	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,900,186	1,527,074	249,472	52,119	151,842	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	0	0	0	0	0	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	61,336	12,726	1,883	0	2,423	194.00
200.00	Cross Foot Adjustments	0				0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	8,961,522	1,539,800	251,355	52,119	154,265	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part I Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	268,758					10.00
11.00	CAFETERIA	141,120	159,387				11.00
13.00	NURSING ADMINISTRATION	0	0	0			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	806	0	132,485		14.00
15.00	PHARMACY	0	0	0	0	364,561	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	3,301	0	0	0	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	114,905	46,637	0	0	0	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	12,924	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	11,597	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	93	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	6,679	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	509	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	132,485	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	364,561	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	13,856	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	193	0	0	0	90.00
91.00	EMERGENCY	0	57,968	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	3,297	0	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	256,025	157,860	0	132,485	364,561	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	12,733	0	0	0	0	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	1,527	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part I Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
202.00	TOTAL (sum lines 118-201)	268,758	159,387	0	132,485	364,561	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part I | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	23.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY	136,994					16.00
23.00	PARAMED ED PRGM	0	0				23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	49,452	0	2,319,017	0	2,319,017	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	21,551	0	1,006,378	0	1,006,378	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	30,239	0	854,426	0	854,426	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	39,448	0	39,448	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	5,012	0	282,101	0	282,101	66.00
69.00	ELECTROCARDIOLOGY	0	0	19,872	0	19,872	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	132,485	0	132,485	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	364,561	0	364,561	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	242,281	0	242,281	88.00
88.01	RURAL HEALTH CLINIC II	0	0	564,856	0	564,856	88.01
88.02	RURAL HEALTH CLINIC III	0	0	340,573	0	340,573	88.02
88.03	RURAL HEALTH CLINIC IV	0	0	328,348	0	328,348	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	2,673	0	12,401	0	12,401	90.00
91.00	EMERGENCY	28,067	0	2,337,358	0	2,337,358	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	24,789	0	24,789	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	136,994	0	8,868,894	0	8,868,894	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	0	0	12,733	0	12,733	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	79,895	0	79,895	194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part I Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	23.00	24.00	25.00	26.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	136,994	0	8,961,522	0	8,961,522	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part II | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	7,483	1,637	8,181	17,301	5.00
7.00	OPERATION OF PLANT	0	2,239	0	1,330	3,569	7.00
8.00	LAUNDRY & LINEN SERVICE	0	2,150	0	693	2,843	8.00
9.00	HOUSEKEEPING	0	449	0	0	449	9.00
10.00	DIETARY	0	3,348	0	181	3,529	10.00
11.00	CAFETERIA	0	2,993	0	0	2,993	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,205	0	0	1,205	14.00
15.00	PHARMACY	0	827	0	0	827	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	1,576	0	290	1,866	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	19,101	0	32,819	51,920	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	3,741	0	184,640	188,381	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	1,981	0	62,871	64,852	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	3,159	0	911	4,070	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	12,833	12,833	88.00
88.01	RURAL HEALTH CLINIC II	0	3,220	0	147	3,367	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	RURAL HEALTH CLINIC IV	0	0	0	12,836	12,836	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	325	0	0	325	90.00
91.00	EMERGENCY	0	5,965	0	4,296	10,261	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	917	0	0	917	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	60,679	1,637	322,028	384,344	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	0	0	0	0	0	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part II Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	385	11,762	0	12,147	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	61,064	13,399	322,028	396,491	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part II | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0					4.00
5.00	ADMINISTRATIVE & GENERAL	0	17,301				5.00
7.00	OPERATION OF PLANT	0	485	4,054			7.00
8.00	LAUNDRY & LINEN SERVICE	0	80	170	3,093		8.00
9.00	HOUSEKEEPING	0	287	35	193	964	9.00
10.00	DIETARY	0	470	264	5	56	10.00
11.00	CAFETERIA	0	7	236	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	243	95	0	0	14.00
15.00	PHARMACY	0	696	65	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	241	124	0	6	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	3,670	1,512	2,065	491	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	1,831	295	140	17	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	1,545	156	0	16	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	76	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	484	249	187	7	66.00
69.00	ELECTROCARDIOLOGY	0	37	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	457	0	1	36	88.00
88.01	RURAL HEALTH CLINIC II	0	986	254	0	152	88.01
88.02	RURAL HEALTH CLINIC III	0	646	0	3	38	88.02
88.03	RURAL HEALTH CLINIC IV	0	623	0	0	36	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	15	26	0	0	90.00
91.00	EMERGENCY	0	4,249	471	413	93	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	30	72	86	1	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	17,158	4,024	3,093	949	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	0	0	0	0	0	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	143	30	0	15	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	17,301	4,054	3,093	964	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part II Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	4,324					10.00
11.00	CAFETERIA	2,270	5,506				11.00
13.00	NURSING ADMINISTRATION	0	0	0			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	28	0	1,571		14.00
15.00	PHARMACY	0	0	0	0	1,588	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	114	0	0	0	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,849	1,611	0	0	0	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	446	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	401	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	3	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	231	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	18	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,571	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,588	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	479	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	7	0	0	0	90.00
91.00	EMERGENCY	0	2,001	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	114	0	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,119	5,453	0	1,571	1,588	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	205	0	0	0	0	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	53	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part II Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
202.00	TOTAL (sum lines 118-201)	4,324	5,506	0	1,571	1,588	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part II | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	23.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY	2,351					16.00
23.00	PARAMED ED PRGM	0	0				23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	848		63,966	0	63,966	30.00
40.00	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
45.00	NURSING FACILITY	0		0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	370		191,480	0	191,480	54.00
57.00	CT SCAN	0		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	519		67,489	0	67,489	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0		79	0	79	63.00
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	PHYSICAL THERAPY	86		5,314	0	5,314	66.00
69.00	ELECTROCARDIOLOGY	0		55	0	55	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1,571	0	1,571	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0		1,588	0	1,588	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0		13,327	0	13,327	88.00
88.01	RURAL HEALTH CLINIC II	0		5,238	0	5,238	88.01
88.02	RURAL HEALTH CLINIC III	0		687	0	687	88.02
88.03	RURAL HEALTH CLINIC IV	0		13,495	0	13,495	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	46		419	0	419	90.00
91.00	EMERGENCY	482		17,970	0	17,970	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0		1,220	0	1,220	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.10	CORF	0		0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	ISLET ACQUISITION	0		0	0	0	111.00
113.00	INTEREST EXPENSE	0		0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0		0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0		0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,351	0	383,898	0	383,898	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	190.00
191.00	RESEARCH	0		0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
192.01	JAIL MEALS	0		205	0	205	192.01
192.02	OUTPATIENT MEALS	0		0	0	0	192.02
192.03	IDLE SPACE	0		0	0	0	192.03
193.00	NONPAID WORKERS	0		0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0		12,388	0	12,388	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B Part II Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	23.00	24.00	25.00	26.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,351	0	396,491	0	396,491	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B-1 | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NON HOSP. (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00	4.00	5A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	37,153					1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	7,074				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP			314,787			2.00
4.00	EMPLOYEE BENEFITS	0	0	0	5,832,294		4.00
5.00	ADMINISTRATIVE & GENERAL	4,553	864	7,997	886,005	-1,539,800	5.00
7.00	OPERATION OF PLANT	1,362	0	1,300	57,583	0	7.00
8.00	LAUNDRY & LINEN SERVICE	1,308	0	677	18,817	0	8.00
9.00	HOUSEKEEPING	273	0	0	76,423	0	9.00
10.00	DIETARY	2,037	0	177	148,773	0	10.00
11.00	CAFETERIA	1,821	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	733	0	0	20,901	0	14.00
15.00	PHARMACY	503	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	959	0	283	85,572	0	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,623	0	32,081	1,209,115	0	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	2,276	0	180,490	335,071	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,205	0	61,457	300,676	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,400	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	1,922	0	891	173,171	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	13,204	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	12,544	128,443	0	88.00
88.01	RURAL HEALTH CLINIC II	1,959	0	144	319,517	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	207,400	0	88.02
88.03	RURAL HEALTH CLINIC IV	0	0	12,547	159,348	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	198	0	0	5,014	0	90.00
91.00	EMERGENCY	3,629	0	4,199	1,559,782	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	558	0	0	85,484	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	36,919	864	314,787	5,792,699	-1,539,800	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	0	0	0	0	0	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B-1 | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NON HOSP. (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
		1.00	1.01	2.00	4.00	5A	
194.00	OTHER NONREIMBURSABLE COST CENTERS	234	6,210	0	39,595	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	61,064	13,399	322,028	804,816		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.643582	1.894119	1.023003	0.137993		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B-1 | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	7,421,722					5.00
7.00	OPERATION OF PLANT	208,166	31,238				7.00
8.00	LAUNDRY & LINEN SERVICE	34,447	1,308	55,335			8.00
9.00	HOUSEKEEPING	123,251	273	3,446	92,315		9.00
10.00	DIETARY	201,541	2,037	85	5,345	20,073	10.00
11.00	CAFETERIA	2,993	1,821	0	0	10,540	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	104,169	733	0	0	0	14.00
15.00	PHARMACY	298,569	503	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	103,493	959	0	605	0	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,574,511	11,623	36,949	46,990	8,582	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	785,599	2,276	2,496	1,585	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	662,814	1,205	0	1,535	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	32,593	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	207,606	1,922	3,351	665	0	66.00
69.00	ELECTROCARDIOLOGY	16,036	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	195,861	0	20	3,450	0	88.00
88.01	RURAL HEALTH CLINIC II	423,065	1,959	0	14,600	0	88.01
88.02	RURAL HEALTH CLINIC III	276,984	0	60	3,630	0	88.02
88.03	RURAL HEALTH CLINIC IV	267,154	0	2	3,450	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	6,577	198	0	0	0	90.00
91.00	EMERGENCY	1,822,243	3,629	7,388	8,890	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	12,714	558	1,538	120	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,360,386	31,004	55,335	90,865	19,122	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	0	0	0	0	951	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	61,336	234	0	1,450	0	194.00
200.00	Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B-1 | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,539,800	251,355	52,119	154,265	268,758	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.207472	8.046450	0.941881	1.671072	13.389030	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	17,301	4,054	3,093	964	4,324	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.002331	0.129778	0.055896	0.010443	0.215414	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B-1 | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	4,132,286					11.00
13.00	NURSING ADMINISTRATION	0	100				13.00
14.00	CENTRAL SERVICES & SUPPLY	20,901	0	100			14.00
15.00	PHARMACY	0	0	0	100		15.00
16.00	MEDICAL RECORDS & LIBRARY	85,572	0	0	0	820	16.00
23.00	PARAMED ED PRGM	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,209,115	100	0	0	296	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	335,071	0	0	0	129	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	300,676	0	0	0	181	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	2,400	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	173,171	0	0	0	30	66.00
69.00	ELECTROCARDIOLOGY	13,204	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	359,245	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	5,014	0	0	0	16	90.00
91.00	EMERGENCY	1,502,838	0	0	0	168	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	85,484	0	0	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,092,691	100	100	100	820	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	JAIL MEALS	0	0	0	0	0	192.01
192.02	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	IDLE SPACE	0	0	0	0	0	192.03
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	39,595	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B-1 | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	159,387	0	132,485	364,561	136,994	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.038571	0.000000	1,324.850000	3,645.610000	167.065854	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	5,506	0	1,571	1,588	2,351	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.001332	0.000000	15.710000	15.880000	2.867073	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B-1 | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
	GENERAL SERVICE COST CENTERS		
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
14.00	CENTRAL SERVICES & SUPPLY		14.00
15.00	PHARMACY		15.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
23.00	PARAMED ED PRGM	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	ADULTS & PEDIATRICS	0	30.00
40.00	SUBPROVIDER - IPF	0	40.00
41.00	SUBPROVIDER - IRF	0	41.00
42.00	SUBPROVIDER	0	42.00
45.00	NURSING FACILITY	0	45.00
	ANCILLARY SERVICE COST CENTERS		
54.00	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	CT SCAN	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	CARDIAC CATHETERIZATION	0	59.00
60.00	LABORATORY	0	60.00
60.01	BLOOD LABORATORY	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	63.00
64.00	INTRAVENOUS THERAPY	0	64.00
66.00	PHYSICAL THERAPY	0	66.00
69.00	ELECTROCARDIOLOGY	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	76.00
	OUTPATIENT SERVICE COST CENTERS		
88.00	RURAL HEALTH CLINIC	0	88.00
88.01	RURAL HEALTH CLINIC II	0	88.01
88.02	RURAL HEALTH CLINIC III	0	88.02
88.03	RURAL HEALTH CLINIC IV	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	CLINIC	0	90.00
91.00	EMERGENCY	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
	OTHER REIMBURSABLE COST CENTERS		
95.00	AMBULANCE SERVICES	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	98.00
99.10	CORF	0	99.10
	SPECIAL PURPOSE COST CENTERS		
109.00	PANCREAS ACQUISITION	0	109.00
110.00	INTESTINAL ACQUISITION	0	110.00
111.00	ISLET ACQUISITION	0	111.00
113.00	INTEREST EXPENSE	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	118.00
	NONREIMBURSABLE COST CENTERS		
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	RESEARCH	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	JAIL MEALS	0	192.01
192.02	OUTPATIENT MEALS	0	192.02
192.03	IDLE SPACE	0	192.03
193.00	NONPAID WORKERS	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
200.00	Cross Foot Adjustments		200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet B-1 | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
		23.00		
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet C Part I Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,319,017		2,319,017	0	0	30.00
40.00	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
45.00	NURSING FACILITY	0		0	0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	1,006,378		1,006,378	0	0	54.00
57.00	CT SCAN	0		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	854,426		854,426	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	39,448		39,448	0	0	63.00
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	PHYSICAL THERAPY	282,101	0	282,101	0	0	66.00
69.00	ELECTROCARDIOLOGY	19,872		19,872	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	132,485		132,485	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	364,561		364,561	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	242,281		242,281	0	0	88.00
88.01	RURAL HEALTH CLINIC II	564,856		564,856	0	0	88.01
88.02	RURAL HEALTH CLINIC III	340,573		340,573	0	0	88.02
88.03	RURAL HEALTH CLINIC IV	328,348		328,348	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	12,401		12,401	0	0	90.00
91.00	EMERGENCY	2,337,358		2,337,358	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	400,725		400,725		0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	24,789		24,789	0	0	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.10	CORF	0		0		0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0		0		0	109.00
110.00	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	ISLET ACQUISITION	0		0		0	111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0		0		0	117.00
200.00	Subtotal (see instructions)	9,269,619	0	9,269,619	0	0	200.00
201.00	Less Observation Beds	400,725		400,725		0	201.00
202.00	Total (see instructions)	8,868,894	0	8,868,894	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet C Part I Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,298,291		1,298,291			30.00
40.00	SUBPROVIDER - IPF	0		0			40.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
45.00	NURSING FACILITY	0		0			45.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	197,668	2,953,862	3,151,530	0.319330	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	225,963	2,308,579	2,534,542	0.337113	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	64,622	144,203	208,825	0.188905	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	PHYSICAL THERAPY	70,871	776,816	847,687	0.332789	0.000000	66.00
69.00	ELECTROCARDIOLOGY	25,200	380,344	405,544	0.049001	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	358,283	412,822	771,105	0.171812	0.000000	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	480,904	497,605	978,509	0.372568	0.000000	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	242,595	242,595			88.00
88.01	RURAL HEALTH CLINIC II	0	350,225	350,225			88.01
88.02	RURAL HEALTH CLINIC III	0	247,150	247,150			88.02
88.03	RURAL HEALTH CLINIC IV	0	190,216	190,216			88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	40	36,855	36,895	0.336116	0.000000	90.00
91.00	EMERGENCY	2,658	1,672,471	1,675,129	1.395330	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	669,318	669,318	0.598706	0.000000	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	1,088,696	1,088,696	0.022769	0.000000	95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
99.10	CORF	0	0	0			99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0			117.00
200.00	Subtotal (see instructions)	2,724,500	11,971,757	14,696,257			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	2,724,500	11,971,757	14,696,257			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet C Part I Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
45.00	NURSING FACILITY			45.00
	ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	INTRAVENOUS THERAPY	0.000000		64.00
66.00	PHYSICAL THERAPY	0.000000		66.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC			88.00
88.01	RURAL HEALTH CLINIC II			88.01
88.02	RURAL HEALTH CLINIC III			88.02
88.03	RURAL HEALTH CLINIC IV			88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	0.000000		95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.10	CORF			99.10
	SPECIAL PURPOSE COST CENTERS			
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
114.00	UTILIZATION REVIEW-SNF			114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)			115.00
117.00	OTHER SPECIAL PURPOSE (SPECIFY)			117.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D Part II Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	191,480	3,151,530	0.060758	139,964	8,504	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	67,489	2,534,542	0.026628	173,839	4,629	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	79	208,825	0.000378	24,459	9	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00	PHYSICAL THERAPY	5,314	847,687	0.006269	7,787	49	66.00
69.00	ELECTROCARDIOLOGY	55	405,544	0.000136	15,078	2	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,571	771,105	0.002037	180,847	368	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,588	978,509	0.001623	239,464	389	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	13,327	242,595	0.054935	0	0	88.00
88.01	RURAL HEALTH CLINIC II	5,238	350,225	0.014956	0	0	88.01
88.02	RURAL HEALTH CLINIC III	687	247,150	0.002780	0	0	88.02
88.03	RURAL HEALTH CLINIC IV	13,495	190,216	0.070946	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	419	36,895	0.011357	0	0	90.00
91.00	EMERGENCY	17,970	1,675,129	0.010728	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	669,318	0.000000	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	318,712	12,309,270		781,438	13,950	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D Part IV Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D Part IV Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	3,151,530	0.000000	0.000000	139,964	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	2,534,542	0.000000	0.000000	173,839	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	208,825	0.000000	0.000000	24,459	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
66.00	PHYSICAL THERAPY	0	847,687	0.000000	0.000000	7,787	66.00
69.00	ELECTROCARDIOLOGY	0	405,544	0.000000	0.000000	15,078	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	771,105	0.000000	0.000000	180,847	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	978,509	0.000000	0.000000	239,464	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	242,595	0.000000	0.000000	0	88.00
88.01	RURAL HEALTH CLINIC II	0	350,225	0.000000	0.000000	0	88.01
88.02	RURAL HEALTH CLINIC III	0	247,150	0.000000	0.000000	0	88.02
88.03	RURAL HEALTH CLINIC IV	0	190,216	0.000000	0.000000	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	36,895	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	1,675,129	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	669,318	0.000000	0.000000	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (lines 50-199)	0	12,309,270			781,438	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D Part IV Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	RURAL HEALTH CLINIC IV	0	0	0		88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D Part V Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0.319330	0	1,294,143	0		54.00
57.00	CT SCAN	0.000000	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	LABORATORY	0.337113	0	1,188,544	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.188905	0	52,074	0		63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
66.00	PHYSICAL THERAPY	0.332789	0	224,394	0		66.00
69.00	ELECTROCARDIOLOGY	0.049001	0	171,453	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171812	0	179,581	0		71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.372568	0	244,230	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
88.01	RURAL HEALTH CLINIC II	0.000000					88.01
88.02	RURAL HEALTH CLINIC III	0.000000					88.02
88.03	RURAL HEALTH CLINIC IV	0.000000					88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	0.336116	0	26,242	0		90.00
91.00	EMERGENCY	1.395330	0	820,533	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.598706	0	248,252	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.022769		0			95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0		98.00
200.00	Subtotal (see instructions)		0	4,449,446	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	4,449,446	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D Part V Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Costs PPS Services (see instructions)	Costs Cost Services Subject To Ded. & Coins. (see instructions)	Costs Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0	413,259	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	400,674	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	9,837	0		63.00
64.00	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	PHYSICAL THERAPY	0	74,676	0		66.00
69.00	ELECTROCARDIOLOGY	0	8,401	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,854	0		71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	90,992	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	RURAL HEALTH CLINIC IV	0	0	0		88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	8,820	0		90.00
91.00	EMERGENCY	0	1,144,914	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	148,630	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Subtotal (see instructions)	0	2,331,057	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	2,331,057	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141300 | Component CCN: 14Z300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D Part V | Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0.319330	0	0	0		54.00
57.00	CT SCAN	0.000000	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	LABORATORY	0.337113	0	0	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.188905	0	0	0		63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
66.00	PHYSICAL THERAPY	0.332789	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0.049001	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171812	0	0	0		71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.372568	0	0	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
88.01	RURAL HEALTH CLINIC II	0.000000					88.01
88.02	RURAL HEALTH CLINIC III	0.000000					88.02
88.03	RURAL HEALTH CLINIC IV	0.000000					88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	0.336116	0	0	0		90.00
91.00	EMERGENCY	1.395330	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.598706	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.022769		0			95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0		98.00
200.00	Subtotal (see instructions)		0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141300 | Component CCN: 14Z300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D Part V | Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Costs: PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	RURAL HEALTH CLINIC IV	0	0	0		88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D-1 | Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,824	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,253	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,253	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	100	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	532	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	409	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	530	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	743	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	632	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,319,017	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	48,062	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	62,280	25.00
26.00	Total swing-bed cost (see instructions)	850,863	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,468,154	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	915,193	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	915,193	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.604202	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	730.40	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,468,154	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,171.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	870,581	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	870,581	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D-1 | Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	231,537	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,102,118	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	740,521	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	740,521	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	342	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,171.71	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	400,725	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D-1 | Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D-3 | Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		752,318		30.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
	ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0.319330	139,964	44,695	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.337113	173,839	58,603	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.188905	24,459	4,620	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	PHYSICAL THERAPY	0.332789	7,787	2,591	66.00
69.00	ELECTROCARDIOLOGY	0.049001	15,078	739	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171812	180,847	31,072	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.372568	239,464	89,217	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	RURAL HEALTH CLINIC IV	0.000000		0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.336116	0	0	90.00
91.00	EMERGENCY	1.395330	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.598706	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		781,438	231,537	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		781,438		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141300 | Component CCN: 14Z300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet D-3 | Date/Time Prepared: 2/7/2012 3:39 pm

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		294,997		30.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
	ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0.319330	30,472	9,731	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.337113	46,141	15,555	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.188905	5,523	1,043	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	PHYSICAL THERAPY	0.332789	61,567	20,489	66.00
69.00	ELECTROCARDIOLOGY	0.049001	6,111	299	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.171812	92,210	15,843	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.372568	121,852	45,398	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	RURAL HEALTH CLINIC IV	0.000000		0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.336116	0	0	90.00
91.00	EMERGENCY	1.395330	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.598706	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		363,876	108,358	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		363,876		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet E Part B Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,331,057	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,331,057	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,354,368	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	26,811	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	648,303	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,679,254	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,679,254	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,679,254	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	130,969	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	130,969	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	120,724	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,810,223	37.00
38.00	MSP-LCC reconciliation amount from PS&R	1,050	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	1,809,173	40.00
41.00	Interim payments	1,192,390	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	616,783	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet E-1 Part I Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Hospital	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,008,045		1,414,767	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	03/11/2011	54,447	03/11/2011	176,376	3.50
3.51		08/26/2011	22,756	08/26/2011	46,001	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-77,203		-222,377	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		930,842		1,192,390	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		22,040		616,783	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		952,882		1,809,173	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet E-1 Part I | Date/Time Prepared: 2/7/2012 3:39 pm

Component CCN: 14Z300 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		770,741		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	03/11/2011	19,847		0	3.50
3.51		08/26/2011	45,469		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-65,316		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		705,425		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		131,400		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		836,825		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141300 Component CCN: 14Z300	Period: From 09/01/2010 To 08/31/2011	Worksheet E-2 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	747,926	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	109,442	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	632	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	857,368	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	857,368	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	857,368	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	20,543	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	836,825	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	836,825	0	19.00
20.00	Interim payments	705,425	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	131,400	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet E-3 Part V Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	1,102,118	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,102,118	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)	1,113,139	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,113,139	19.00
20.00	Deductibles (exclude professional component)	182,793	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	930,346	22.00
23.00	Coinsurance	1,981	23.00
24.00	Subtotal (line 22 minus line 23)	928,365	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24,517	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	24,517	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,320	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)	952,882	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	952,882	30.00
31.00	Interim payments	930,842	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	22,040	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet G | Date/Time Prepared: 2/7/2012 3:39 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	-115,692	0	0	0	1.00
2.00	Temporary investments	29,296	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,104,519	0	0	0	4.00
5.00	Other receivable	286,154	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,581,680	0	0	0	6.00
7.00	Inventory	23,446	0	0	0	7.00
8.00	Prepaid expenses	102,827	0	0	0	8.00
9.00	Other current assets	79,980	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,928,850	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	70,515	0	0	0	12.00
13.00	Land improvements	36,143	0	0	0	13.00
14.00	Accumulated depreciation	-36,143	0	0	0	14.00
15.00	Buildings	2,453,859	0	0	0	15.00
16.00	Accumulated depreciation	-2,213,634	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	84,028	0	0	0	19.00
20.00	Accumulated depreciation	-81,045	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,722,996	0	0	0	23.00
24.00	Accumulated depreciation	-1,484,138	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	552,581	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	2,481,431	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,353,917	0	0	0	37.00
38.00	Salaries, wages, and fees payable	418,527	0	0	0	38.00
39.00	Payroll taxes payable	64,662	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,180,589	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	158,438	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,176,133	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	818,180	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	818,180	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,994,313	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,512,882				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,512,882	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	2,481,431	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet G-1 | Date/Time Prepared: 2/7/2012 3:39 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		10,559		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,548,196				2.00
3.00	Total (sum of line 1 and line 2)		-1,537,637		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,537,637		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,537,637		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet G-1 | Date/Time Prepared: 2/7/2012 3:39 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141300 | Period: From 09/01/2010 To 08/31/2011 | Worksheet G-2 Parts | Date/Time Prepared: 2/7/2012 3:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	871,541		871,541	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	367,742		367,742	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,239,283		1,239,283	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,239,283		1,239,283	17.00
18.00	Ancillary services	1,605,833	0	1,605,833	18.00
19.00	Outpatient services	0	10,680,123	10,680,123	19.00
20.00	RURAL HEALTH CLINIC	0	242,595	242,595	20.00
20.01	RURAL HEALTH CLINIC II	0	350,225	350,225	20.01
20.02	RURAL HEALTH CLINIC III	0	247,150	247,150	20.02
20.03	RURAL HEALTH CLINIC IV	0	190,216	190,216	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,088,696	1,088,696	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,845,116	12,799,005	15,644,121	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		9,528,478		29.00
30.00	BAD DEBTS	1,102,354			30.00
31.00	INTEREST EXPENSE	82,608			31.00
32.00	HEALTHLINK FEES	32,758			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,217,720		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		10,746,198		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141300	Period: From 09/01/2010 To 08/31/2011	Worksheet G-3 Date/Time Prepared: 2/7/2012 3:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	15,644,121	1.00
2.00	Less contractual allowances and discounts on patients' accounts	6,989,658	2.00
3.00	Net patient revenues (line 1 minus line 2)	8,654,463	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	10,746,198	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,091,735	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	50,087	6.00
7.00	Income from investments	6,663	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	37,065	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	5,332	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	WELL CTR/AMB/NON-REIMB/GAIN LOSS	444,392	24.00
25.00	Total other income (sum of lines 6-24)	543,539	25.00
26.00	Total (line 5 plus line 25)	-1,548,196	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,548,196	29.00

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

Provider CCN: 141300 | Component CCN: 143403 | Period: From 09/01/2010 To 08/31/2011 | Worksheet M-1 | Date/Time Prepared: 2/7/2012 3:39 pm

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	5,308	366	5,674	0	5,674	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	85,907	5,930	91,837	0	91,837	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	39,076	2,697	41,773	0	41,773	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	28,093	1,939	30,032	-28,107	1,925	9.00
10.00	Subtotal (sum of lines 1-9)	158,384	10,932	169,316	-28,107	141,209	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	11,500	11,500	0	11,500	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	11,500	11,500	0	11,500	14.00
15.00	Medical Supplies	0	2,404	2,404	0	2,404	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	2,520	2,520	18.00
19.00	Other Health Care Costs	0	17,949	17,949	-10,278	7,671	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	20,353	20,353	-7,758	12,595	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	158,384	42,785	201,169	-35,865	165,304	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	158,384	42,785	201,169	-35,865	165,304	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141300 Component CCN: 143403	Period: From 09/01/2010 To 08/31/2011	Worksheet M-1 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	5,674		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	91,837		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	41,773		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	1,925		9.00
10.00	Subtotal (sum of lines 1-9)	0	141,209		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	11,500		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	11,500		14.00
15.00	Medical Supplies	0	2,404		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	2,520		18.00
19.00	Other Health Care Costs	0	7,671		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	12,595		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	165,304		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	165,304		32.00

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

Provider CCN: 141300 | Component CCN: 143475 | Period: From 09/01/2010 To 08/31/2011 | Worksheet M-1 | Date/Time Prepared: 2/7/2012 3:39 pm

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	4,379	135	4,514	24,830	29,344	1.00
2.00	Physician Assistant	109,669	3,369	113,038	0	113,038	2.00
3.00	Nurse Practitioner	85,677	2,632	88,309	0	88,309	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	76,976	2,365	79,341	0	79,341	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	78,774	2,418	81,192	0	81,192	9.00
10.00	Subtotal (sum of lines 1-9)	355,475	10,919	366,394	24,830	391,224	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	23,788	23,788	0	23,788	12.00
13.00	Other Costs Under Agreement	0	0	0	-57,537	-57,537	13.00
14.00	Subtotal (sum of lines 11-13)	0	23,788	23,788	-57,537	-33,749	14.00
15.00	Medical Supplies	0	10,508	10,508	0	10,508	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	7,560	7,560	18.00
19.00	Other Health Care Costs	0	7,785	7,785	-7,721	64	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	18,293	18,293	-161	18,132	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	355,475	53,000	408,475	-32,868	375,607	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	355,475	53,000	408,475	-32,868	375,607	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141300 Component CCN: 143475	Period: From 09/01/2010 To 08/31/2011	Worksheet M-1 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	29,344		1.00
2.00	Physician Assistant	0	113,038		2.00
3.00	Nurse Practitioner	0	88,309		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	79,341		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	81,192		9.00
10.00	Subtotal (sum of lines 1-9)	0	391,224		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	23,788		12.00
13.00	Other Costs Under Agreement	0	-57,537		13.00
14.00	Subtotal (sum of lines 11-13)	0	-33,749		14.00
15.00	Medical Supplies	0	10,508		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	7,560		18.00
19.00	Other Health Care Costs	0	64		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	18,132		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	375,607		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	375,607		32.00

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

Provider CCN: 141300 | Component CCN: 143474 | Period: From 09/01/2010 To 08/31/2011 | Worksheet M-1 | Date/Time Prepared: 2/7/2012 3:39 pm

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	144,747	9,846	154,593	0	154,593	1.00
2.00	Physician Assistant	11,902	810	12,712	0	12,712	2.00
3.00	Nurse Practitioner	21,976	1,495	23,471	0	23,471	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	29,267	1,991	31,258	0	31,258	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	49,373	3,358	52,731	-57,718	-4,987	9.00
10.00	Subtotal (sum of lines 1-9)	257,265	17,500	274,765	-57,718	217,047	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	5,713	5,713	0	5,713	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	9,118	9,118	18.00
19.00	Other Health Care Costs	0	16,486	16,486	0	16,486	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	22,199	22,199	9,118	31,317	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	257,265	39,699	296,964	-48,600	248,364	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	257,265	39,699	296,964	-48,600	248,364	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141300 Component CCN: 143474	Period: From 09/01/2010 To 08/31/2011	Worksheet M-1 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) III	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	154,593		1.00
2.00	Physician Assistant	0	12,712		2.00
3.00	Nurse Practitioner	0	23,471		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	31,258		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	-4,987		9.00
10.00	Subtotal (sum of lines 1-9)	0	217,047		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	5,713		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	9,118		18.00
19.00	Other Health Care Costs	0	16,486		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	31,317		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	248,364		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	248,364		32.00

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

Provider CCN: 141300 | Component CCN: 143476 | Period: From 09/01/2010 To 08/31/2011 | Worksheet M-1 | Date/Time Prepared: 2/7/2012 3:39 pm

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	114,399	9,812	124,211	0	124,211	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	10,396	892	11,288	0	11,288	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	36,907	3,165	40,072	0	40,072	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	33,598	2,882	36,480	-42,565	-6,085	9.00
10.00	Subtotal (sum of lines 1-9)	195,300	16,751	212,051	-42,565	169,486	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	12,000	12,000	0	12,000	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	12,000	12,000	0	12,000	14.00
15.00	Medical Supplies	0	5,050	5,050	0	5,050	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	27,601	27,601	18.00
19.00	Other Health Care Costs	0	16,192	16,192	2,000	18,192	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	21,242	21,242	29,601	50,843	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	195,300	49,993	245,293	-12,964	232,329	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	195,300	49,993	245,293	-12,964	232,329	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141300 Component CCN: 143476	Period: From 09/01/2010 To 08/31/2011	Worksheet M-1 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) IV	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	124,211		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	11,288		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	40,072		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	-6,085		9.00
10.00	Subtotal (sum of lines 1-9)	0	169,486		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	12,000		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	12,000		14.00
15.00	Medical Supplies	0	5,050		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	27,601		18.00
19.00	Other Health Care Costs	0	18,192		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	50,843		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	232,329		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	232,329		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141300 | Period: From 09/01/2010 | Worksheet M-2
Component CCN: 143403 | To 08/31/2011 | Date/Time Prepared: 2/7/2012 3:39 pm

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.92	1,635	2,100	1,932		3.00
4.00	Subtotal (sum of lines 1-3)	0.92	1,635		1,932	1,932	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.92	1,635			1,932	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					165,304	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					165,304	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					76,977	15.00
16.00	Total overhead (sum of lines 14 and 15)					76,977	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					76,977	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					76,977	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					242,281	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141300 | Period: From 09/01/2010 | Worksheet M-2
Component CCN: 143475 | To 08/31/2011 | Date/Time Prepared: 2/7/2012 3:39 pm
Title XVIII | Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.13	888	4,200	546		1.00
2.00	Physician Assistant	1.28	2,860	2,100	2,688		2.00
3.00	Nurse Practitioner	1.00	2,286	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1-3)	2.41	6,034		5,334	6,034	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.41	6,034			6,034	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					375,607	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					375,607	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					189,249	15.00
16.00	Total overhead (sum of lines 14 and 15)					189,249	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					189,249	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					189,249	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					564,856	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141300 | Period: From 09/01/2010 | Worksheet M-2
Component CCN: 143474 | To 08/31/2011 | Date/Time Prepared: 2/7/2012 3:39 pm
Title XVIII | Rural Health Clinic (RHC) III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.72	2,547	4,200	3,024		1.00
2.00	Physician Assistant	0.15	313	2,100	315		2.00
3.00	Nurse Practitioner	0.24	521	2,100	504		3.00
4.00	Subtotal (sum of lines 1-3)	1.11	3,381		3,843	3,843	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.11	3,381			3,843	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					248,364	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					248,364	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					92,209	15.00
16.00	Total overhead (sum of lines 14 and 15)					92,209	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					92,209	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					92,209	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					340,573	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 141300 | Component CCN: 143476 | Period: From 09/01/2010 To 08/31/2011 | Worksheet M-2 | Date/Time Prepared: 2/7/2012 3:39 pm

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.52	1,609	4,200	2,184		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.10	303	2,100	210		3.00
4.00	Subtotal (sum of lines 1-3)	0.62	1,912		2,394	2,394	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.62	1,912			2,394	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					232,329	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					232,329	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					96,019	15.00
16.00	Total overhead (sum of lines 14 and 15)					96,019	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					96,019	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					96,019	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					328,348	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141300 Component CCN: 143403	Period: From 09/01/2010 To 08/31/2011	Worksheet M-3 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

				1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)			242,281	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)			6,713	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			235,568	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)			1,932	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1,932	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			121.93	7.00
			Calculation of Limit (1)		
			Prior to January 1	On on After January 1	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)		999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)		121.93	121.93	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)		108	216	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		13,168	26,337	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		13,168	26,337	16.00
16.01	Total program charges (see instructions)(from contractor's records)			16,220	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)			17,342	16.04
16.05	Total program cost (see instructions)		10,534	17,342	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			4,660	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			3,910	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			27,876	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			2,812	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			30,688	22.00
23.00	Reimbursable bad debts (see instructions)			0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)			30,688	26.00
27.00	Interim payments			16,358	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)			14,330	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141300 Component CCN: 143475	Period: From 09/01/2010 To 08/31/2011	Worksheet M-3 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		564,856	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		1,925	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		562,931	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		6,034	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,034	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		93.29	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)	93.29	93.29	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	220	440	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	20,524	41,048	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	20,524	41,048	16.00
16.01	Total program charges (see instructions)(from contractor's records)		35,350	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		25,672	16.04
16.05	Total program cost (see instructions)	16,419	25,672	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,958	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,813	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		42,091	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		146	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		42,237	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		42,237	26.00
27.00	Interim payments		36,417	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		5,820	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141300 Component CCN: 143474	Period: From 09/01/2010 To 08/31/2011	Worksheet M-3 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) III	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		340,573	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		13,880	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		326,693	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,843	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,843	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		85.01	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)	85.01	85.01	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	405	809	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	34,429	68,773	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	34,429	68,773	16.00
16.01	Total program charges (see instructions)(from contractor's records)		67,803	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		40,671	16.04
16.05	Total program cost (see instructions)	27,543	40,671	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		17,934	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,762	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		68,214	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,197	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		74,411	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		74,411	26.00
27.00	Interim payments		54,009	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		20,402	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141300 Component CCN: 143476	Period: From 09/01/2010 To 08/31/2011	Worksheet M-3 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) IV	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		328,348	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		7,390	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		320,958	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,394	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,394	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		134.07	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)	134.07	134.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	235	470	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	31,506	63,013	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	31,506	63,013	16.00
16.01	Total program charges (see instructions)(from contractor's records)		38,256	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		41,394	16.04
16.05	Total program cost (see instructions)	25,205	41,394	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,271	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,223	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		66,599	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,954	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		69,553	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		69,553	26.00
27.00	Interim payments		61,362	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		8,191	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141300 Component CCN: 143403	Period: From 09/01/2010 To 08/31/2011	Worksheet M-4 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	141,209	141,209	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.023618	0.000576	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3,335	81	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,145	19	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,480	100	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	165,304	165,304	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	76,977	76,977	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.027102	0.000605	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,086	47	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	6,566	147	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	101	1	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	65.01	147.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	41	1	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,665	147	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		6,713	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		2,812	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141300 Component CCN: 143475	Period: From 09/01/2010 To 08/31/2011	Worksheet M-4 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	391,224	391,224	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000982	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	384	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	896	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,280	0	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	375,607	375,607	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	189,249	189,249	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003408	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	645	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,925	0	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	79	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	24.37	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	146	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		1,925	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		146	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141300 Component CCN: 143474	Period: From 09/01/2010 To 08/31/2011	Worksheet M-4 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) III	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	217,047	217,047	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.029082	0.002987	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	6,312	648	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,877	285	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	9,189	933	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	248,364	248,364	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	92,209	92,209	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.036998	0.003757	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,412	346	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	12,601	1,279	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	254	15	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	49.61	85.27	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	106	11	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,259	938	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		13,880	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		6,197	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141300 Component CCN: 143476	Period: From 09/01/2010 To 08/31/2011	Worksheet M-4 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) IV	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	169,486	169,486	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.021298	0.001486	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3,610	252	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,213	154	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,823	406	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	232,329	232,329	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	96,019	96,019	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.020759	0.001748	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,993	168	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	6,816	574	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	107	8	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	63.70	71.75	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	43	3	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,739	215	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		7,390	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		2,954	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141300 Component CCN: 143403	Period: From 09/01/2010 To 08/31/2011	Worksheet M-5 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		15,864	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/11/2011	494	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		494	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		16,358	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		14,330	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		30,688	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141300 Component CCN: 143475	Period: From 09/01/2010 To 08/31/2011	Worksheet M-5 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		34,994	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/11/2011	1,423	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1,423	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		36,417	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		5,820	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		42,237	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141300 Component CCN: 143474	Period: From 09/01/2010 To 08/31/2011	Worksheet M-5 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		52,470	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/11/2011	1,539	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1,539	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		54,009	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		20,402	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		74,411	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141300 Component CCN: 143476	Period: From 09/01/2010 To 08/31/2011	Worksheet M-5 Date/Time Prepared: 2/7/2012 3:39 pm
	Title XVIII	Rural Health Clinic (RHC) IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		47,075	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/11/2011	14,287	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		14,287	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		61,362	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		8,191	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		69,553	7.00

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