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: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 1/27/2012 4:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 1/27/2012 Time: 4:05 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] 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 MEMORIAL HOSPITAL ASSOCIATION for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 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	2,238	165,332	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	85,931	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		-481		0	10.00
10.01	RURAL HEALTH CLINIC II II	0		-6,780		0	10.01
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	88,169	158,071	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/27/2012 3:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SOUTH ADAMS STREET	PO Box: 160			1.00
2.00	City: CARTHAGE	State: IL	Zip Code: 62321-	County: HANCOCK	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	MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O	O	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	MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	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									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BOWEN CLINIC	143456	99914		02/05/1999	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1	ADAMS STREET CLINIC	143405	99914		08/01/1995	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2010	06/30/2011	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.	2	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

		Beginning: 1.00	Ending: 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 3:39 pm

		Beginning:	Ending:	
		1.00	2.00	
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: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 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: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 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.	Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		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.	1,000,000	3,000,000	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.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 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)	Y		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	N	N	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: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/27/2012 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)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			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	11/01/2011	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: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/27/2012 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				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				Y	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: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/27/2012 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	11/01/2011	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.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2012 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	18	6,885	45,984.00		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)		18	6,885	45,984.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00		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	43.00					13.00
14.00	Total (see instructions)		18	6,885	45,984.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	57	20,805			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.01	RURAL HEALTH CLINIC II	88.01					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00	Total (sum of lines 14-26)		75				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2012 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	1,120	404	1,856		1.00
2.00	HMO		83	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	539	0	668		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	31		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,659	404	2,555		7.00
8.00	INTENSIVE CARE UNIT	0	0	0	0		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	0		105	228		13.00
14.00	Total (see instructions)	0	1,659	509	2,783		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE				13,239		21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	695	0	3,376		26.00
26.01	RURAL HEALTH CLINIC II	0	377	0	5,881		26.01
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		0	451		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	60		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2012 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	304	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	145.04	0.00	0	304	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00	49.10	0.00			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00	3.88	0.00			26.00
26.01	RURAL HEALTH CLINIC II	0.00	6.23	0.00			26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00	Total (sum of lines 14-26)	0.00	204.25	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/27/2012 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)	135	611		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)	135	611		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE		0		21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.01	RURAL HEALTH CLINIC II				26.01
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
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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S-7 Date/Time Prepared: 1/27/2012 3:39 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	Y		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	08/08/2000	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S-7 Date/Time Prepared: 1/27/2012 3:39 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0			207.00

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

Provider CCN: 141305 Component CCN: 143456 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-8 | Date/Time Prepared: 1/27/2012 3:39 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	209 EAST 5TH ST	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	BOWEN IL	62316 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
9.01		0	9.01
9.02		0	9.02
9.03		0	9.03
9.04		0	9.04
9.05		0	9.05
9.06		0	9.06
9.07		0	9.07
9.08		0	9.08
9.09		0	9.09
9.10		0	9.10
		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)		0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/27/2012 3:39 pm
		Rural Health Clinic (RHC) I	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	HANCOCK					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	18:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/27/2012 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	16:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/27/2012 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: 141305 Component CCN: 143405

Period: From 07/01/2010 To 06/30/2011

Worksheet S-8

Date/Time Prepared: 1/27/2012 3:39 pm

Rural Health Clinic (RHC) II

Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			213 SOUTH ADAMS STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	CARTHAGE		IL	62321	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
9.01				0		9.01
9.02				0		9.02
9.03				0		9.03
9.04				0		9.04
9.05				0		9.05
9.06				0		9.06
9.07				0		9.07
9.08				0		9.08
9.09				0		9.09
9.10				0		9.10
				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	20:00		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: 141305 Component CCN: 143405	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/27/2012 3:39 pm
		Rural Health Clinic (RHC) II	Cost

			County					
			4.00					
2.00	City, State, Zip Code, County		HANCOCK					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	20:00	08:00	17:00			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141305 Component CCN: 143405	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/27/2012 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	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141305 Component CCN: 143405	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/27/2012 3:39 pm
		Rural Health Clinic (RHC) II	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/27/2012 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)	0.670215	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,773,693	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	873,823	5.00
6.00	Medicaid charges	7,326,468	6.00
7.00	Medicaid cost (line 1 times line 6)	4,910,309	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)	2,262,793	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	281,698	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,262,793	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	319,046	283,583	602,629	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	213,829	190,062	403,891	21.00
22.00	Partial payment by patients approved for charity care	12,254	23,044	35,298	22.00
23.00	Cost of charity care (line 21 minus line 22)	201,575	167,018	368,593	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)	891,231	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	357,584	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	533,647	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	357,658	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	726,251	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,989,044	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/27/2012 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		1,182,560	1,182,560	-1,160,451	22,109	1.00
1.01	NEW CAP REL COSTS-NH BLDG		172,173	172,173	-36,260	135,913	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	2,370,765	2,370,765	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP		696,932	696,932	33,099	730,031	2.00
2.01	NEW CAP REL COSTS-NH ME		0	0	29,332	29,332	2.01
3.00	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	EMPLOYEE BENEFITS	0	1,759,255	1,759,255	-49,434	1,709,821	4.00
4.01	SHARED HUMAN RESOURCES	67,852	16,884	84,736	0	84,736	4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G	238,337	1,079,885	1,318,222	272,995	1,591,217	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	846,550	237,759	1,084,309	0	1,084,309	5.02
7.00	OPERATION OF PLANT	114,437	496,478	610,915	0	610,915	7.00
7.01	OPERATION OF PLANT NURSING HOME	103,095	334,099	437,194	0	437,194	7.01
8.00	LAUNDRY & LINEN SERVICE	0	43,507	43,507	0	43,507	8.00
9.00	HOUSEKEEPING	79,574	31,582	111,156	0	111,156	9.00
9.01	HOUSEKEEPING NURSING HOME	96,643	21,833	118,476	0	118,476	9.01
10.00	DIETARY	153,533	87,437	240,970	-118,692	122,278	10.00
11.00	CAFETERIA	0	0	0	118,692	118,692	11.00
13.00	NURSING ADMINISTRATION	97,466	12,343	109,809	0	109,809	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	135,355	25,365	160,720	26,094	186,814	16.00
17.00	SOCIAL SERVICE	18,932	767	19,699	0	19,699	17.00
19.00	NONPHYSICIAN ANESTHETISTS	345,458	11,089	356,547	0	356,547	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,010,500	8,398	1,018,898	99,807	1,118,705	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	0	0	128,524	128,524	43.00
46.00	OTHER LONG TERM CARE	973,586	952,185	1,925,771	-18,254	1,907,517	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	250,840	87,325	338,165	0	338,165	50.00
52.00	DELIVERY ROOM & LABOR ROOM	289,154	6,687	295,841	-228,159	67,682	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	403,538	529,089	932,627	0	932,627	54.00
56.00	RADIOISOTOPE	0	69,438	69,438	0	69,438	56.00
60.00	LABORATORY	337,265	770,455	1,107,720	0	1,107,720	60.00
60.02	GEO PSYCH	63,011	252,181	315,192	0	315,192	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	74,863	74,863	0	74,863	62.00
65.00	RESPIRATORY THERAPY	150,455	47,583	198,038	-1,971	196,067	65.00
66.00	PHYSICAL THERAPY	0	46,268	46,268	0	46,268	66.00
69.00	ELECTROCARDIOLOGY	0	7,657	7,657	1,971	9,628	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,665	334,488	365,153	-10,259	354,894	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,259	10,259	72.00
73.00	DRUGS CHARGED TO PATIENTS	128,399	478,153	606,552	0	606,552	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	163,143	72,677	235,820	-15,178	220,642	88.00
88.01	RURAL HEALTH CLINIC II	550,758	218,913	769,671	-103,671	666,000	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	1,478,914	363,860	1,842,774	-124,074	1,718,700	90.00
91.00	EMERGENCY	601,252	616,733	1,217,985	11,318	1,229,303	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
93.01	DIABETIC EDUCATION	36,906	2,192	39,098	0	39,098	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		1,310,763	1,310,763	-1,310,763	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,765,618	12,459,856	21,225,474	-74,310	21,151,164	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	121,319	61,793	183,112	67,382	250,494	192.00
194.00	NAUVOO APARTMENTS	0	14,285	14,285	6,928	21,213	194.00
194.02	BEAUTY SHOP	6,114	1,317	7,431	0	7,431	194.02
200.00	TOTAL (SUM OF LINES 118-199)	8,893,051	12,537,251	21,430,302	0	21,430,302	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/27/2012 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	0	22,109		1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	135,913		1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-20,759	2,350,006		1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	730,031		2.00
2.01	NEW CAP REL COSTS-NH ME	0	29,332		2.01
3.00	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	EMPLOYEE BENEFITS	-57,978	1,651,843		4.00
4.01	SHARED HUMAN RESOURCES	0	84,736		4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G	-406,561	1,184,656		5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	-1,037	1,083,272		5.02
7.00	OPERATION OF PLANT	-80,736	530,179		7.00
7.01	OPERATION OF PLANT NURSING HOME	0	437,194		7.01
8.00	LAUNDRY & LINEN SERVICE	0	43,507		8.00
9.00	HOUSEKEEPING	0	111,156		9.00
9.01	HOUSEKEEPING NURSING HOME	0	118,476		9.01
10.00	DIETARY	-1,580	120,698		10.00
11.00	CAFETERIA	-33,391	85,301		11.00
13.00	NURSING ADMINISTRATION	0	109,809		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	PHARMACY	0	0		15.00
16.00	MEDICAL RECORDS & LIBRARY	-3,898	182,916		16.00
17.00	SOCIAL SERVICE	0	19,699		17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	356,547		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,118,705		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
43.00	NURSERY	0	128,524		43.00
46.00	OTHER LONG TERM CARE	-191,094	1,716,423		46.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	338,165		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	67,682		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	932,627		54.00
56.00	RADIOISOTOPE	0	69,438		56.00
60.00	LABORATORY	-2,746	1,104,974		60.00
60.02	GEO PSYCH	-13,087	302,105		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	74,863		62.00
65.00	RESPIRATORY THERAPY	-750	195,317		65.00
66.00	PHYSICAL THERAPY	0	46,268		66.00
69.00	ELECTROCARDIOLOGY	0	9,628		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-7,372	347,522		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	10,259		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	606,552		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-2,744	217,898		88.00
88.01	RURAL HEALTH CLINIC II	-17,008	648,992		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	-1,127,147	591,553		90.00
91.00	EMERGENCY	-147,269	1,082,034		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	DIABETIC EDUCATION	0	39,098		93.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	0		95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,115,157	19,036,007		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	250,494		192.00
194.00	NAUVOO APARTMENTS	0	21,213		194.00
194.02	BEAUTY SHOP	0	7,431		194.02
200.00	TOTAL (SUM OF LINES 118-199)	-2,115,157	19,315,145		200.00

RECLASSIFICATIONS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/27/2012 3:39 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-NH ME	2.01	0	29,332		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,157,891		2.00
3.00	NAUVOO APARTMENTS	194.00	0	6,928		3.00
	TOTALS		0	1,194,151		
	B - TO RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	75,624	43,068		1.00
	TOTALS		75,624	43,068		
	C - TO RECLASS RHC DEPR EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	2,560		1.00
	TOTALS		0	2,560		
	E - TO RECLASS INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	33,099		1.00
2.00	HOSPITAL ONLY BUS OFF AND A&G	5.01	0	64,790		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,212,874		3.00
	TOTALS		0	1,310,763		
	F - TO RECLASS DELIVERY AND LABOR					
1.00	ADULTS & PEDIATRICS	30.00	97,383	2,252		1.00
2.00	NURSERY	43.00	125,619	2,905		2.00
	TOTALS		223,002	5,157		
	G - TO RECLASS BILLING AND TRANSCRIPTION					
1.00	HOSPITAL ONLY BUS OFF AND A&G	5.01	208,205	0		1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	26,094		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		208,205	26,094		
	H - TO RECLASS EKG TIME					
1.00	ELECTROCARDIOLOGY	69.00	7,315	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	5,344		2.00
	TOTALS		7,315	5,344		
	I - TO RECLASS DR LYNCH AND JONES TIME					
1.00	RURAL HEALTH CLINIC II	88.01	4,498	289		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	87,456	0		2.00
	TOTALS		91,954	289		
	J - RECLASS S WATSON TO SWING					
1.00	ADULTS & PEDIATRICS	30.00	172	0		1.00
	TOTALS		172	0		
	K - RECLASS ALLOWABLE PHYSICIAN FICA					
1.00	CLINIC	90.00	0	38,116		1.00
2.00	EMERGENCY	91.00	0	11,318		2.00
	TOTALS		0	49,434		
	L - TO RECLASS CLINIC CAFETERIA COSTS					
1.00	CLINIC	90.00	0	18,082		1.00
	TOTALS		0	18,082		
	M - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,259		1.00
	TOTALS		0	10,259		
500.00	Grand Total: Increases		606,272	2,665,201		500.00

RECLASSIFICATIONS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/27/2012 3:39 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-NH BLDG	1.01	0	29,332	9		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,157,891	9		2.00
3.00	NEW CAP REL COSTS-NH BLDG	1.01	0	6,928	9		3.00
	TOTALS		0	1,194,151			
	B - TO RECLASS CAFETERIA						
1.00	DIETARY	10.00	75,624	43,068	0		1.00
	TOTALS		75,624	43,068			
	C - TO RECLASS RHC DEPR EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,560	9		1.00
	TOTALS		0	2,560			
	E - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,310,763	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	1,310,763			
	F - TO RECLASS DELIVERY AND LABOR						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	97,383	2,252	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	125,619	2,905	0		2.00
	TOTALS		223,002	5,157			
	G - TO RECLASS BILLING AND TRANSCRIPTION						
1.00	CLINIC	90.00	0	26,094	0		1.00
2.00	CLINIC	90.00	149,391	0	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	17,738	0	0		3.00
4.00	RURAL HEALTH CLINIC II	88.01	21,002	0	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	20,074	0	0		5.00
	TOTALS		208,205	26,094			
	H - TO RECLASS EKG TIME						
1.00	RESPIRATORY THERAPY	65.00	7,315	0	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	5,344	0		2.00
	TOTALS		7,315	5,344			
	I - TO RECLASS DR LYNCH AND JONES TIME						
1.00	CLINIC	90.00	4,498	289	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	87,456	0	0		2.00
	TOTALS		91,954	289			
	J - RECLASS S WATSON TO SWING						
1.00	OTHER LONG TERM CARE	46.00	172	0	0		1.00
	TOTALS		172	0			
	K - RECLASS ALLOWABLE PHYSICIAN FICA						
1.00	EMPLOYEE BENEFITS	4.00	0	49,434	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	49,434			
	L - TO RECLASS CLINIC CAFETERIA COSTS						
1.00	OTHER LONG TERM CARE	46.00	0	18,082	0		1.00
	TOTALS		0	18,082			
	M - IMPLANTABLE SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,259	0		1.00
	TOTALS		0	10,259			
500.00	Grand Total: Decreases		606,272	2,665,201			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/27/2012 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	521,757	0	0	0	0	1.00
2.00	Land Improvements	341,880	5,476	0	5,476	0	2.00
3.00	Buildings and Fixtures	23,594,223	91,384	0	91,384	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,614,307	199,222	0	199,222	18,053	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,072,167	296,082	0	296,082	18,053	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,072,167	296,082	0	296,082	18,053	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	1,182,560	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-NH BLDG	172,173	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	696,932	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,051,665	0	0	0	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	347,356	0	347,356	0.011080	0	1.00
1.01	NEW CAP REL COSTS-NH BLDG	3,153,023	0	3,153,023	0.100574	0	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	21,054,340	0	21,054,340	0.671586	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,282,435	0	6,282,435	0.200395	0	2.00
2.01	NEW CAP REL COSTS-NH ME	513,042	0	513,042	0.016365	0	2.01
3.00	Total (sum of lines 1-2)	31,350,196	0	31,350,196	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/27/2012 3:39 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	521,757	0				1.00
2.00	Land Improvements	347,356	0				2.00
3.00	Buildings and Fixtures	23,685,607	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	6,795,476	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	31,350,196	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	31,350,196	0				10.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,182,560				1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	172,173				1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0				1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	696,932				2.00
2.01	NEW CAP REL COSTS-NH ME	0	0				2.01
3.00	Total (sum of lines 1-2)	0	2,051,665				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	22,109	0	1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	0	0	135,913	0	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	1,156,859	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	696,932	0	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	0	29,332	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	2,041,145	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/27/2012 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	0	0	0	22,109	1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	0	0	0	135,913	1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,193,147	0	0	0	2,350,006	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	33,099	0	0	0	730,031	2.00
2.01	NEW CAP REL COSTS-NH ME	0	0	0	0	29,332	2.01
3.00	Total (sum of lines 1-2)	1,226,246	0	0	0	3,267,391	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/27/2012 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)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-1,032	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	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)	A	-1,775	HOSPITAL ONLY BUS OFF AND A&G	5.01	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,093,393			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	-91,368			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-33,391	CAFETERIA	11.00	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	-3,898	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines	B	-1,580	DIETARY	10.00	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	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - 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	NONPHYSICIAN ANESTHETISTS	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	RENT INCOME	B	-19,880	CLINIC	90.00	33.00
34.00	DR SPACE	B	-3,037	CLINIC	90.00	34.00
35.00	IT MISC REVENUE	B	-1,037	OTHER ADMINISTRATIVE AND GENERAL SHA	5.02	35.00
36.00	LOBBYING	A	-7,331	HOSPITAL ONLY BUS OFF AND A&G	5.01	36.00
37.00	NEUROLOGY RENT	B	-750	RESPIRATORY THERAPY	65.00	37.00
38.00	PHYS RECRUITMENT	A	-42,807	HOSPITAL ONLY BUS OFF AND A&G	5.01	38.00
39.00	ADVERTISING - HOSPITAL	A	-26,074	HOSPITAL ONLY BUS OFF AND A&G	5.01	39.00
40.00	ADVERTSING- BOWEN	A	-2,744	RURAL HEALTH CLINIC	88.00	40.00
41.00	ADVERTISING - CLINIC	A	-4,742	CLINIC	90.00	41.00
42.00	SUPPLIES SOLD	A	-7,372	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	42.00
43.00	PROFESSIONL LIABILITY	A	-138,887	CLINIC	90.00	43.00
44.00	UNNECESSARY BORROWING	A	-19,727	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	44.00
45.00	CLINIC SALARY REIMBURSEMENT	B	-68,001	CLINIC	90.00	45.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/27/2012 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	
45.01	GEO PSYCH SALARY REIMBURSEMENT	B	-13,050	GEO PSYCH	60.02	45.01
45.02	RENTAL INCOME - MIDWEST	B	-4,454	CLINIC	90.00	45.02
45.03	RENTAL INCOME MISC	B	-18,607	HOSPITAL ONLY BUS OFF AND A&G	5.01	45.03
45.04	MISC INCOME	B	-3,651	HOSPITAL ONLY BUS OFF AND A&G	5.01	45.04
45.05	ADVERTISING - WOMENS	A	-4,576	RURAL HEALTH CLINIC II	88.01	45.05
45.06	RENTAL INCOME WOMEN'S CLINIC	B	-1,800	RURAL HEALTH CLINIC II	88.01	45.06
45.07	MISC INCOME - PRAIRIE CARDIOVASCULAR	B	-2,746	LABORATORY	60.00	45.07
45.08	PURCHASE DISCOUNTS	B	-18,576	HOSPITAL ONLY BUS OFF AND A&G	5.01	45.08
45.09	MISC INCOME - GERO PHYS	B	-37	GEO PSYCH	60.02	45.09
45.10	PROVIDER TAX	A	-168,152	HOSPITAL ONLY BUS OFF AND A&G	5.01	45.10
45.11	CAPITAL CAMPAIGN FUND RAISING	A	-292	HOSPITAL ONLY BUS OFF AND A&G	5.01	45.11
45.14	MISC INCOME	B	-21,807	OTHER LONG TERM CARE	46.00	45.14
45.15	MARKETING SALARIES	A	-51,535	HOSPITAL ONLY BUS OFF AND A&G	5.01	45.15
45.16	MARKETING FRINGES	A	-9,167	HOSPITAL ONLY BUS OFF AND A&G	5.01	45.16
45.17	LINE OF CREDIT INTEREST	A	-36,570	HOSPITAL ONLY BUS OFF AND A&G	5.01	45.17
45.18	CITY OF CARTHAGE INTEREST	A	-22,024	HOSPITAL ONLY BUS OFF AND A&G	5.01	45.18
45.19	NURSING HOME DIETARY REVENUE	B	-139,052	OTHER LONG TERM CARE	46.00	45.19
45.20	NURSING HOME LAUNDRY REVENUE	B	-8,425	OTHER LONG TERM CARE	46.00	45.20
45.21	NURSING HOME SLF REVENUE	B	-16,574	OTHER LONG TERM CARE	46.00	45.21
45.24	NURSING HOME RENTAL INCOME	B	-5,236	OTHER LONG TERM CARE	46.00	45.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,115,157			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/27/2012 3:39 pm

		Wkst. A-7 Ref. 5.00		
1.00	Investment income - buildings and fixtures (chapter 2)	0		1.00
2.00	Investment income - movable equipment (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	9		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	RENT INCOME	0		33.00
34.00	DR SPACE	0		34.00
35.00	IT MISC REVENUE	0		35.00
36.00	LOBBYING	0		36.00
37.00	NEUROLOGY RENT	0		37.00
38.00	PHYS RECRUITMENT	0		38.00
39.00	ADVERTISING - HOSPITAL	0		39.00
40.00	ADVERTSING- BOWEN	0		40.00
41.00	ADVERTISING - CLINIC	0		41.00
42.00	SUPPLIES SOLD	0		42.00
43.00	PROFESSIONL LIABILITY	0		43.00
44.00	UNNECESSARY BORROWING	11		44.00
45.00	CLINIC SALARY REIMBURSEMENT	0		45.00
45.01	GEO PSYCH SALARY REIMBURSEMENT	0		45.01
45.02	RENTAL INCOME - MIDWEST	0		45.02
45.03	RENTAL INCOME MISC	0		45.03
45.04	MISC INCOME	0		45.04
45.05	ADVERTISING - WOMENS	0		45.05
45.06	RENTAL INCOME WOMEN'S CLINIC	0		45.06
45.07	MISC INCOME - PRAIRIE CARDIOVASCULAR	0		45.07
45.08	PURCHASE DISCOUNTS	0		45.08
45.09	MISC INCOME - GERO PHYS	0		45.09
45.10	PROVIDER TAX	0		45.10
45.11	CAPITAL CAMPAIGN FUND RAISING	0		45.11
45.14	MISC INCOME	0		45.14
45.15	MARKETING SALARIES	0		45.15
45.16	MARKETING FRINGES	0		45.16
45.17	LINE OF CREDIT INTEREST	0		45.17

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/27/2012 3:39 pm

		Wkst. A-7 Ref.		
		5.00		
45.18	CITY OF CARTHAGE INTEREST	0		45.18
45.19	NURSING HOME DIETARY REVENUE	0		45.19
45.20	NURSING HOME LAUNDRY REVENUE	0		45.20
45.21	NURSING HOME SLF REVENUE	0		45.21
45.24	NURSING HOME RENTAL INCOME	0		45.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-1 Date/Time Prepared: 1/27/2012 3:39 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		7.00	OPERATION OF PLANT	RENT	1.00
2.00		88.01	RURAL HEALTH CLINIC II	RENT	2.00
3.00		0.00			3.00
4.00		0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		C	MEMORIAL HOSPIT	0.00		6.00
7.00				0.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-1 Date/Time Prepared: 1/27/2012 3:39 pm

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		0	80,736	-80,736	0		1.00
2.00		0	10,632	-10,632	0		2.00
3.00		0	0	0	0		3.00
4.00		0	0	0	0		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	0	91,368	-91,368			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		HANCOCK COUNTY NURSING	100.00	SNF-NON-CERTIFIED	6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/27/2012 3:39 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		60.00	LABORATORY	19,200	0	1.00
2.00		56.00	RADIOISOTOPE	4,800	0	2.00
3.00		90.00	CLINIC PHYSICIAN SALARIES	888,146	888,146	3.00
4.00		91.00	ER FEES	932,898	147,269	4.00
5.00		4.00	CLINIC EMPLOYEE BENEFITS	54,448	54,448	5.00
6.00		4.00	ER EMPLOYEE BENEFITS	3,530	3,530	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)	1,903,022	1,093,393	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/27/2012 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		19,200	0	0	0	0	1.00
2.00		4,800	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		785,629	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		809,629		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/27/2012 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: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/27/2012 3:39 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	0		1.00
2.00		0	0		2.00
3.00		0	888,146		3.00
4.00		0	147,269		4.00
5.00		0	54,448		5.00
6.00		0	3,530		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	1,093,393		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/27/2012 3:39 pm

		Physical Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		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	138.25	0.00	343.75	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.88	0.00	36.44	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.44	36.44	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		10,076	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)		10,076	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		12,526	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)		22,602	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)		72.88	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		56,846	22.00
23.00	Total salary equivalency (see instructions)		69,372	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)		0	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)		0	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)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/27/2012 3:39 pm

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.88	0.00	36.44	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)		69,372	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)		69,372	63.00
64.00	Total cost of outside supplier services (from your records)		28,790	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		0	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		0	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		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/27/2012 3:39 pm
		Occupational Therapy	Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						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	62.00	0.00	214.75	0.00		9.00
10.00	AHSEA (see instructions)	0.00	69.07	0.00	34.54	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)	34.54	34.54	0.00				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						4,282	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)						4,282	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						7,417	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)						11,699	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)						69.06	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						53,867	22.00
23.00	Total salary equivalency (see instructions)						61,284	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)						0	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)						0	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)						0	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/27/2012 3:39 pm
		Occupational Therapy	Cost

						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.07	0.00	34.54	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)	61,284		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)	61,284		63.00
64.00	Total cost of outside supplier services (from your records)	15,945		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	0		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	0		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	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW NH BLDG	NEW BLDG & FIXT (NEW B	NEW MVBLE EQUIP	
		0	1.00	1.01	1.02	2.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	22,109	22,109				1.00
1.01	NEW CAP REL COSTS-NH BLDG	135,913	0	135,913			1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	2,350,006	0	0	2,350,006		1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	730,031				730,031	2.00
2.01	NEW CAP REL COSTS-NH ME	29,332				0	2.01
4.00	EMPLOYEE BENEFITS	1,651,843	0	0	0	0	4.00
4.01	SHARED HUMAN RESOURCES	84,736	0	0	0	0	4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G	1,184,656	7,673	11,969	564,452	188,069	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	1,083,272	0	10,569	0	0	5.02
7.00	OPERATION OF PLANT	530,179	1,169	0	116,470	36,576	7.00
7.01	OPERATION OF PLANT NURSING HOME	437,194	0	12,587	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	43,507	0	0	10,084	2,622	8.00
9.00	HOUSEKEEPING	111,156	0	0	25,266	6,569	9.00
9.01	HOUSEKEEPING NURSING HOME	118,476	0	699	0	0	9.01
10.00	DIETARY	120,698	0	0	47,763	12,418	10.00
11.00	CAFETERIA	85,301	0	0	27,206	7,073	11.00
13.00	NURSING ADMINISTRATION	109,809	0	0	14,683	3,818	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	182,916	2,400	4,656	43,607	24,259	16.00
17.00	SOCIAL SERVICE	19,699	0	0	9,697	2,521	17.00
19.00	NONPHYSICIAN ANESTHETISTS	356,547	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,118,705	0	0	542,011	140,918	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	128,524	0	0	12,467	3,241	43.00
46.00	OTHER LONG TERM CARE	1,716,423	0	75,368	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	338,165	0	0	222,024	57,724	50.00
52.00	DELIVERY ROOM & LABOR ROOM	67,682	0	0	49,092	12,764	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	932,627	0	0	245,406	63,804	54.00
56.00	RADIOISOTOPE	69,438	0	0	17,177	4,466	56.00
60.00	LABORATORY	1,104,974	190	0	93,530	25,340	60.00
60.02	GEO PSYCH	302,105	3,200	0	0	17,229	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	74,863	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	195,317	0	3,544	38,288	9,954	65.00
66.00	PHYSICAL THERAPY	46,268	0	1,174	14,351	3,731	66.00
69.00	ELECTROCARDIOLOGY	9,628	0	0	62,335	16,207	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	347,522	0	4,666	18,063	4,696	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	10,259	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	606,552	96	2,767	69,317	18,540	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	217,898	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	648,992	0	0	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	591,553	6,763	0	0	36,418	90.00
91.00	EMERGENCY	1,082,034	0	0	102,617	26,680	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
93.01	DIABETIC EDUCATION	39,098	618	0	0	3,328	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,036,007	22,109	127,999	2,345,906	728,965	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,100	1,066	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	250,494	0	7,337	0	0	192.00
194.00	NAUVOO APARTMENTS	21,213	0	0	0	0	194.00
194.02	BEAUTY SHOP	7,431	0	577	0	0	194.02
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)	19,315,145	22,109	135,913	2,350,006	730,031	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	CAPITAL RELATED COSTS NEW NH ME	EMPLOYEE BENEFITS	SHARED HUMAN RESOURCES	HOSPITAL ONLY BUS OFF AND A&G	Subtotal	
		2.01	4.00	4.01	5.01	5A.01	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME	29,332					2.01
4.00	EMPLOYEE BENEFITS	0	1,651,843				4.00
4.01	SHARED HUMAN RESOURCES	0	13,868	98,604			4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G	0	109,533	5,585	2,071,937		5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	2,825	200,985	10,588	182,972	1,491,211	5.02
7.00	OPERATION OF PLANT	0	28,070	1,431	99,846	813,741	7.00
7.01	OPERATION OF PLANT NURSING HOME	0	0	1,289	0	451,070	7.01
8.00	LAUNDRY & LINEN SERVICE	0	0	0	7,862	64,075	8.00
9.00	HOUSEKEEPING	0	19,519	995	22,868	186,373	9.00
9.01	HOUSEKEEPING NURSING HOME	0	0	1,209	0	120,384	9.01
10.00	DIETARY	0	19,110	974	28,107	229,070	10.00
11.00	CAFETERIA	0	18,550	946	19,451	158,527	11.00
13.00	NURSING ADMINISTRATION	0	23,908	1,219	21,460	174,897	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	33,201	1,693	40,942	333,674	16.00
17.00	SOCIAL SERVICE	0	4,644	237	5,147	41,945	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	84,738	4,321	62,323	507,929	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	271,796	13,857	291,925	2,379,212	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	30,813	1,571	24,702	201,318	43.00
46.00	OTHER LONG TERM CARE	24,053	0	12,174	0	1,828,018	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	61,529	3,137	95,466	778,045	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	16,227	827	20,502	167,094	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	98,985	5,047	188,235	1,534,104	54.00
56.00	RADIOISOTOPE	0	0	0	12,739	103,820	56.00
60.00	LABORATORY	0	82,728	4,218	183,355	1,494,335	60.00
60.02	GEO PSYCH	0	15,456	788	47,382	386,160	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	10,470	85,333	62.00
65.00	RESPIRATORY THERAPY	0	35,111	1,790	39,721	323,725	65.00
66.00	PHYSICAL THERAPY	314	0	0	9,208	75,046	66.00
69.00	ELECTROCARDIOLOGY	0	1,794	91	12,595	102,650	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,247	7,522	384	53,721	437,821	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,435	11,694	72.00
73.00	DRUGS CHARGED TO PATIENTS	739	31,495	1,606	102,254	833,366	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	35,667	1,819	35,718	291,102	88.00
88.01	RURAL HEALTH CLINIC II	0	109,596	5,588	106,878	871,054	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	107,163	5,464	104,527	851,888	90.00
91.00	EMERGENCY	0	134,495	6,858	189,188	1,541,872	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
93.01	DIABETIC EDUCATION	0	9,053	462	7,351	59,910	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,178	1,605,556	96,168	2,028,350	18,930,463	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	723	5,889	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	46,287	2,360	42,864	349,342	192.00
194.00	NAUVOO APARTMENTS	0	0	0	0	21,213	194.00
194.02	BEAUTY SHOP	154	0	76	0	8,238	194.02
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	29,332	1,651,843	98,604	2,071,937	19,315,145	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL SHA	OPERATION OF PLANT	OPERATION OF PLANT NURSING HOME	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.02	7.00	7.01	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS						4.00
4.01	SHARED HUMAN RESOURCES						4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	1,491,211					5.02
7.00	OPERATION OF PLANT	68,080	881,821				7.00
7.01	OPERATION OF PLANT NURSING HOME	37,738	0	488,808			7.01
8.00	LAUNDRY & LINEN SERVICE	5,361	5,328	0	74,764		8.00
9.00	HOUSEKEEPING	15,593	13,349	0	0	215,315	9.00
9.01	HOUSEKEEPING NURSING HOME	10,072	0	3,389	0	0	9.01
10.00	DIETARY	19,165	25,234	0	0	6,295	10.00
11.00	CAFETERIA	13,263	14,374	0	1,452	3,586	11.00
13.00	NURSING ADMINISTRATION	14,632	7,758	0	0	1,935	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	27,916	23,039	22,581	0	5,747	16.00
17.00	SOCIAL SERVICE	3,509	5,123	0	0	1,278	17.00
19.00	NONPHYSICIAN ANESTHETISTS	42,495	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	199,057	286,357	0	35,566	71,434	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	16,843	6,587	0	0	1,643	43.00
46.00	OTHER LONG TERM CARE	152,937	0	365,529	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	65,094	117,301	0	13,207	29,261	50.00
52.00	DELIVERY ROOM & LABOR ROOM	13,980	25,937	0	0	6,470	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	128,348	129,655	0	10,866	32,343	54.00
56.00	RADIOISOTOPE	8,686	9,075	0	0	2,264	56.00
60.00	LABORATORY	125,021	49,415	0	570	12,327	60.00
60.02	GEO PSYCH	32,307	0	0	0	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	7,139	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	27,084	20,228	17,190	1,728	5,046	65.00
66.00	PHYSICAL THERAPY	6,279	7,582	5,691	0	1,891	66.00
69.00	ELECTROCARDIOLOGY	8,588	32,933	0	0	8,215	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,629	9,543	22,627	0	2,381	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	978	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	69,722	36,622	13,419	0	9,135	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	24,354	0	0	220	0	88.00
88.01	RURAL HEALTH CLINIC II	72,875	0	0	1,036	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	71,272	0	0	1,297	0	90.00
91.00	EMERGENCY	128,998	54,215	0	8,612	13,524	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
93.01	DIABETIC EDUCATION	5,012	0	0	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,459,027	879,655	450,426	74,554	214,775	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	493	2,166	0	0	540	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	29,227	0	35,583	0	0	192.00
194.00	NAUVOO APARTMENTS	1,775	0	0	210	0	194.00
194.02	BEAUTY SHOP	689	0	2,799	0	0	194.02
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)	1,491,211	881,821	488,808	74,764	215,315	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	HOUSEKEEPING NURSING HOME	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.01	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS						4.00
4.01	SHARED HUMAN RESOURCES						4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA						5.02
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT NURSING HOME						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
9.01	HOUSEKEEPING NURSING HOME	133,845					9.01
10.00	DIETARY	0	279,764				10.00
11.00	CAFETERIA	0	0	191,202			11.00
13.00	NURSING ADMINISTRATION	0	0	4,369	203,591		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	6,226	0	13,223	0	0	16.00
17.00	SOCIAL SERVICE	0	0	1,499	1,757	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	2,499	2,930	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	279,764	56,861	66,682	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	0	7,339	8,607	0	43.00
46.00	OTHER LONG TERM CARE	100,788	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	12,051	14,132	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	3,856	4,522	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	20,177	23,662	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	LABORATORY	0	0	22,352	26,212	0	60.00
60.02	GEO PSYCH	0	0	5,703	6,688	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	4,740	0	9,511	11,153	0	65.00
66.00	PHYSICAL THERAPY	1,569	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,239	0	2,198	2,577	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,700	0	4,990	5,852	0	73.00
	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
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	22,638	26,547	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
93.01	DIABETIC EDUCATION	0	0	1,936	2,270	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	123,262	279,764	191,202	203,591	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	9,811	0	0	0	0	192.00
194.00	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	BEAUTY SHOP	772	0	0	0	0	194.02
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)	133,845	279,764	191,202	203,591	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		15.00	16.00	17.00	19.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS						4.00
4.01	SHARED HUMAN RESOURCES						4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA						5.02
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT NURSING HOME						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
9.01	HOUSEKEEPING NURSING HOME						9.01
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	0					15.00
16.00	MEDICAL RECORDS & LIBRARY	0	432,406				16.00
17.00	SOCIAL SERVICE	0	0	55,111			17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	555,853		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	39,244	53,785	0	3,467,962	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	1,110	0	0	243,447	43.00
46.00	OTHER LONG TERM CARE	0	0	0	0	2,447,272	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	18,613	0	0	1,047,704	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,251	0	0	223,110	52.00
53.00	ANESTHESIOLOGY	0	15,092	0	555,853	570,945	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	84,460	0	0	1,963,615	54.00
56.00	RADIOISOTOPE	0	7,016	0	0	130,861	56.00
60.00	LABORATORY	0	83,872	0	0	1,814,104	60.00
60.02	GEO PSYCH	0	7,092	0	0	437,950	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,657	0	0	94,129	62.00
65.00	RESPIRATORY THERAPY	0	8,740	0	0	429,145	65.00
66.00	PHYSICAL THERAPY	0	1,950	0	0	100,008	66.00
69.00	ELECTROCARDIOLOGY	0	5,098	0	0	157,484	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,785	0	0	535,800	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	12,672	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	22,712	0	0	999,518	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	5,804	0	0	321,480	88.00
88.01	RURAL HEALTH CLINIC II	0	15,019	0	0	959,984	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	5,362	0	0	929,819	90.00
91.00	EMERGENCY	0	24,266	1,326	0	1,821,998	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
93.01	DIABETIC EDUCATION	0	353	0	0	69,481	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	364,496	55,111	555,853	18,778,488	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	9,088	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	67,910	0	0	491,873	192.00
194.00	NAUVOO APARTMENTS	0	0	0	0	23,198	194.00
194.02	BEAUTY SHOP	0	0	0	0	12,498	194.02
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)	0	432,406	55,111	555,853	19,315,145	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	NEW CAP REL COSTS-NH BLDG				1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	NEW CAP REL COSTS-NH ME				2.01
4.00	EMPLOYEE BENEFITS				4.00
4.01	SHARED HUMAN RESOURCES				4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G				5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA				5.02
7.00	OPERATION OF PLANT				7.00
7.01	OPERATION OF PLANT NURSING HOME				7.01
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
9.01	HOUSEKEEPING NURSING HOME				9.01
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
17.00	SOCIAL SERVICE				17.00
19.00	NONPHYSICIAN ANESTHETISTS				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	3,467,962		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
43.00	NURSERY	0	243,447		43.00
46.00	OTHER LONG TERM CARE	0	2,447,272		46.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,047,704		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	223,110		52.00
53.00	ANESTHESIOLOGY	0	570,945		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,963,615		54.00
56.00	RADIOISOTOPE	0	130,861		56.00
60.00	LABORATORY	0	1,814,104		60.00
60.02	GEO PSYCH	0	437,950		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	94,129		62.00
65.00	RESPIRATORY THERAPY	0	429,145		65.00
66.00	PHYSICAL THERAPY	0	100,008		66.00
69.00	ELECTROCARDIOLOGY	0	157,484		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	535,800		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	12,672		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	999,518		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	321,480		88.00
88.01	RURAL HEALTH CLINIC II	0	959,984		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	929,819		90.00
91.00	EMERGENCY	0	1,821,998		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	DIABETIC EDUCATION	0	69,481		93.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	0		95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	18,778,488		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,088		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	491,873		192.00
194.00	NAUVOO APARTMENTS	0	23,198		194.00
194.02	BEAUTY SHOP	0	12,498		194.02
200.00	Cross Foot Adjustments	0	0		200.00
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	19,315,145		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW NH BLDG	NEW BLDG & FIXT (NEW B	NEW MVBLE EQUIP	
		0	1.00	1.01	1.02	2.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
4.01	SHARED HUMAN RESOURCES	0	0	0	0	0	4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G	0	7,673	11,969	564,452	188,069	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	0	0	10,569	0	0	5.02
7.00	OPERATION OF PLANT	0	1,169	0	116,470	36,576	7.00
7.01	OPERATION OF PLANT NURSING HOME	0	0	12,587	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	0	0	0	10,084	2,622	8.00
9.00	HOUSEKEEPING	0	0	0	25,266	6,569	9.00
9.01	HOUSEKEEPING NURSING HOME	0	0	699	0	0	9.01
10.00	DIETARY	0	0	0	47,763	12,418	10.00
11.00	CAFETERIA	0	0	0	27,206	7,073	11.00
13.00	NURSING ADMINISTRATION	0	0	0	14,683	3,818	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	2,400	4,656	43,607	24,259	16.00
17.00	SOCIAL SERVICE	0	0	0	9,697	2,521	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	0	542,011	140,918	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	0	0	12,467	3,241	43.00
46.00	OTHER LONG TERM CARE	0	0	75,368	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	222,024	57,724	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	49,092	12,764	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	245,406	63,804	54.00
56.00	RADIOISOTOPE	0	0	0	17,177	4,466	56.00
60.00	LABORATORY	0	190	0	93,530	25,340	60.00
60.02	GEO PSYCH	0	3,200	0	0	17,229	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	3,544	38,288	9,954	65.00
66.00	PHYSICAL THERAPY	0	0	1,174	14,351	3,731	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	62,335	16,207	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,666	18,063	4,696	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	96	2,767	69,317	18,540	73.00
	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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	6,763	0	0	36,418	90.00
91.00	EMERGENCY	0	0	0	102,617	26,680	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
93.01	DIABETIC EDUCATION	0	618	0	0	3,328	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	22,109	127,999	2,345,906	728,965	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,100	1,066	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	7,337	0	0	192.00
194.00	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	BEAUTY SHOP	0	0	577	0	0	194.02
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)	0	22,109	135,913	2,350,006	730,031	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	CAPITAL RELATED COSTS NEW NH ME	Subtotal	EMPLOYEE BENEFITS	SHARED HUMAN RESOURCES	HOSPITAL ONLY BUS OFF AND A&G	
		2.01	2A	4.00	4.01	5.01	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS	0	0	0			4.00
4.01	SHARED HUMAN RESOURCES	0	0	0	0		4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G	0	772,163	0	0	772,163	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	2,825	13,394	0	0	68,189	5.02
7.00	OPERATION OF PLANT	0	154,215	0	0	37,210	7.00
7.01	OPERATION OF PLANT NURSING HOME	0	12,587	0	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	0	12,706	0	0	2,930	8.00
9.00	HOUSEKEEPING	0	31,835	0	0	8,522	9.00
9.01	HOUSEKEEPING NURSING HOME	0	699	0	0	0	9.01
10.00	DIETARY	0	60,181	0	0	10,475	10.00
11.00	CAFETERIA	0	34,279	0	0	7,249	11.00
13.00	NURSING ADMINISTRATION	0	18,501	0	0	7,998	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	74,922	0	0	15,258	16.00
17.00	SOCIAL SERVICE	0	12,218	0	0	1,918	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	23,226	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	682,929	0	0	108,794	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	15,708	0	0	9,206	43.00
46.00	OTHER LONG TERM CARE	24,053	99,421	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	279,748	0	0	35,578	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	61,856	0	0	7,641	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	309,210	0	0	70,151	54.00
56.00	RADIOISOTOPE	0	21,643	0	0	4,747	56.00
60.00	LABORATORY	0	119,060	0	0	68,332	60.00
60.02	GEO PSYCH	0	20,429	0	0	17,658	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	3,902	62.00
65.00	RESPIRATORY THERAPY	0	51,786	0	0	14,803	65.00
66.00	PHYSICAL THERAPY	314	19,570	0	0	3,432	66.00
69.00	ELECTROCARDIOLOGY	0	78,542	0	0	4,694	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,247	28,672	0	0	20,020	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	535	72.00
73.00	DRUGS CHARGED TO PATIENTS	739	91,459	0	0	38,108	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	13,311	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	39,831	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	43,181	0	0	38,955	90.00
91.00	EMERGENCY	0	129,297	0	0	70,506	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
93.01	DIABETIC EDUCATION	0	3,946	0	0	2,740	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,178	3,254,157	0	0	755,919	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,166	0	0	269	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	7,337	0	0	15,975	192.00
194.00	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	BEAUTY SHOP	154	731	0	0	0	194.02
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	29,332	3,267,391	0	0	772,163	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL SHA	OPERATION OF PLANT	OPERATION OF PLANT NURSING HOME	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.02	7.00	7.01	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS						4.00
4.01	SHARED HUMAN RESOURCES						4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	81,583					5.02
7.00	OPERATION OF PLANT	3,724	195,149				7.00
7.01	OPERATION OF PLANT NURSING HOME	2,065	0	14,652			7.01
8.00	LAUNDRY & LINEN SERVICE	293	1,179	0	17,108		8.00
9.00	HOUSEKEEPING	853	2,954	0	0	44,164	9.00
9.01	HOUSEKEEPING NURSING HOME	551	0	102	0	0	9.01
10.00	DIETARY	1,048	5,584	0	0	1,291	10.00
11.00	CAFETERIA	726	3,181	0	332	735	11.00
13.00	NURSING ADMINISTRATION	801	1,717	0	0	397	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,527	5,099	677	0	1,179	16.00
17.00	SOCIAL SERVICE	192	1,134	0	0	262	17.00
19.00	NONPHYSICIAN ANESTHETISTS	2,325	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	10,892	63,371	0	8,140	14,653	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	921	1,458	0	0	337	43.00
46.00	OTHER LONG TERM CARE	8,367	0	10,956	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,561	25,959	0	3,022	6,002	50.00
52.00	DELIVERY ROOM & LABOR ROOM	765	5,740	0	0	1,327	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,022	28,693	0	2,486	6,634	54.00
56.00	RADIOISOTOPE	475	2,008	0	0	464	56.00
60.00	LABORATORY	6,840	10,936	0	130	2,528	60.00
60.02	GEO PSYCH	1,767	0	0	0	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	391	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	1,482	4,477	515	395	1,035	65.00
66.00	PHYSICAL THERAPY	343	1,678	171	0	388	66.00
69.00	ELECTROCARDIOLOGY	470	7,288	0	0	1,685	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,004	2,112	678	0	488	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	54	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,814	8,104	402	0	1,874	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,332	0	0	50	0	88.00
88.01	RURAL HEALTH CLINIC II	3,987	0	0	237	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	3,899	0	0	297	0	90.00
91.00	EMERGENCY	7,057	11,998	0	1,971	2,774	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
93.01	DIABETIC EDUCATION	274	0	0	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	79,822	194,670	13,501	17,060	44,053	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27	479	0	0	111	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,599	0	1,067	0	0	192.00
194.00	NAUVOO APARTMENTS	97	0	0	48	0	194.00
194.02	BEAUTY SHOP	38	0	84	0	0	194.02
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)	81,583	195,149	14,652	17,108	44,164	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	HOUSEKEEPING NURSING HOME	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.01	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS						4.00
4.01	SHARED HUMAN RESOURCES						4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA						5.02
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT NURSING HOME						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
9.01	HOUSEKEEPING NURSING HOME	1,352					9.01
10.00	DIETARY	0	78,579				10.00
11.00	CAFETERIA	0	0	46,502			11.00
13.00	NURSING ADMINISTRATION	0	0	1,063	30,477		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	63	0	3,216	0	0	16.00
17.00	SOCIAL SERVICE	0	0	364	263	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	608	439	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	78,579	13,829	9,981	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	0	1,785	1,288	0	43.00
46.00	OTHER LONG TERM CARE	1,018	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	2,931	2,116	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	938	677	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	4,907	3,542	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	LABORATORY	0	0	5,436	3,924	0	60.00
60.02	GEO PSYCH	0	0	1,387	1,001	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	48	0	2,313	1,670	0	65.00
66.00	PHYSICAL THERAPY	16	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	63	0	534	386	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	37	0	1,214	876	0	73.00
	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
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	5,506	3,974	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
93.01	DIABETIC EDUCATION	0	0	471	340	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,245	78,579	46,502	30,477	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	99	0	0	0	0	192.00
194.00	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	BEAUTY SHOP	8	0	0	0	0	194.02
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)	1,352	78,579	46,502	30,477	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		15.00	16.00	17.00	19.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS						4.00
4.01	SHARED HUMAN RESOURCES						4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA						5.02
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT NURSING HOME						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
9.01	HOUSEKEEPING NURSING HOME						9.01
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	0					15.00
16.00	MEDICAL RECORDS & LIBRARY	0	101,941				16.00
17.00	SOCIAL SERVICE	0	0	16,351			17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	26,598		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	9,250	15,958		1,016,376	30.00
31.00	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	NURSERY	0	262	0		30,965	43.00
46.00	OTHER LONG TERM CARE	0	0	0		119,762	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	4,387	0		363,304	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	295	0		79,239	52.00
53.00	ANESTHESIOLOGY	0	3,557	0		3,557	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	19,923	0		452,568	54.00
56.00	RADIOISOTOPE	0	1,654	0		30,991	56.00
60.00	LABORATORY	0	19,770	0		236,956	60.00
60.02	GEO PSYCH	0	1,672	0		43,914	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	391	0		4,684	62.00
65.00	RESPIRATORY THERAPY	0	2,060	0		80,584	65.00
66.00	PHYSICAL THERAPY	0	460	0		26,058	66.00
69.00	ELECTROCARDIOLOGY	0	1,202	0		93,881	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,721	0		58,678	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		589	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,354	0		151,242	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,368	0		16,061	88.00
88.01	RURAL HEALTH CLINIC II	0	3,540	0		47,595	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	89.00
90.00	CLINIC	0	1,264	0		87,596	90.00
91.00	EMERGENCY	0	5,720	393		239,196	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		0	93.00
93.01	DIABETIC EDUCATION	0	83	0		7,854	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0		0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0		0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	85,933	16,351	0	3,191,650	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		6,052	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	16,008	0		42,085	192.00
194.00	NAUVOO APARTMENTS	0	0	0		145	194.00
194.02	BEAUTY SHOP	0	0	0		861	194.02
200.00	Cross Foot Adjustments				26,598	26,598	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	101,941	16,351	26,598	3,267,391	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	NEW CAP REL COSTS-NH BLDG				1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	NEW CAP REL COSTS-NH ME				2.01
4.00	EMPLOYEE BENEFITS				4.00
4.01	SHARED HUMAN RESOURCES				4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G				5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA				5.02
7.00	OPERATION OF PLANT				7.00
7.01	OPERATION OF PLANT NURSING HOME				7.01
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
9.01	HOUSEKEEPING NURSING HOME				9.01
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
17.00	SOCIAL SERVICE				17.00
19.00	NONPHYSICIAN ANESTHETISTS				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,016,376		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
43.00	NURSERY	0	30,965		43.00
46.00	OTHER LONG TERM CARE	0	119,762		46.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	363,304		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	79,239		52.00
53.00	ANESTHESIOLOGY	0	3,557		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	452,568		54.00
56.00	RADIOISOTOPE	0	30,991		56.00
60.00	LABORATORY	0	236,956		60.00
60.02	GEO PSYCH	0	43,914		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,684		62.00
65.00	RESPIRATORY THERAPY	0	80,584		65.00
66.00	PHYSICAL THERAPY	0	26,058		66.00
69.00	ELECTROCARDIOLOGY	0	93,881		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	58,678		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	589		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	151,242		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	16,061		88.00
88.01	RURAL HEALTH CLINIC II	0	47,595		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	87,596		90.00
91.00	EMERGENCY	0	239,196		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	DIABETIC EDUCATION	0	7,854		93.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	0		95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,191,650		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,052		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	42,085		192.00
194.00	NAUVOO APARTMENTS	0	145		194.00
194.02	BEAUTY SHOP	0	861		194.02
200.00	Cross Foot Adjustments	0	26,598		200.00
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	3,267,391		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (OLD HOSP/PBC SQUARE)	NEW NH BLDG (NH/MSS SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	NEW MVBLE EQUIP (HOSP SQUARE FEET)	NEW NH ME (NH SQUARE FEET)	
		1.00	1.01	1.02	2.00	2.01	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	8,264					1.00
1.01	NEW CAP REL COSTS-NH BLDG	0	56,981				1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	42,412			1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP				50,676		2.00
2.01	NEW CAP REL COSTS-NH ME				0	46,015	2.01
4.00	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
4.01	SHARED HUMAN RESOURCES	0	0	0	0	0	4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G	2,868	5,018	10,187	13,055	0	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	0	4,431	0	0	4,431	5.02
7.00	OPERATION OF PLANT	437	0	2,102	2,539	0	7.00
7.01	OPERATION OF PLANT NURSING HOME	0	5,277	0	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	0	0	182	182	0	8.00
9.00	HOUSEKEEPING	0	0	456	456	0	9.00
9.01	HOUSEKEEPING NURSING HOME	0	293	0	0	0	9.01
10.00	DIETARY	0	0	862	862	0	10.00
11.00	CAFETERIA	0	0	491	491	0	11.00
13.00	NURSING ADMINISTRATION	0	0	265	265	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	897	1,952	787	1,684	0	16.00
17.00	SOCIAL SERVICE	0	0	175	175	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	9,782	9,782	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	0	225	225	0	43.00
46.00	OTHER LONG TERM CARE	0	31,598	0	0	37,734	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	4,007	4,007	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	886	886	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	4,429	4,429	0	54.00
56.00	RADIOISOTOPE	0	0	310	310	0	56.00
60.00	LABORATORY	71	0	1,688	1,759	0	60.00
60.02	GEO PSYCH	1,196	0	0	1,196	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	1,486	691	691	0	65.00
66.00	PHYSICAL THERAPY	0	492	259	259	492	66.00
69.00	ELECTROCARDIOLOGY	0	0	1,125	1,125	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,956	326	326	1,956	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	36	1,160	1,251	1,287	1,160	73.00
	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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	2,528	0	0	2,528	0	90.00
91.00	EMERGENCY	0	0	1,852	1,852	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
93.01	DIABETIC EDUCATION	231	0	0	231	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,264	53,663	42,338	50,602	45,773	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	74	74	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,076	0	0	0	192.00
194.00	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	BEAUTY SHOP	0	242	0	0	242	194.02
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)	22,109	135,913	2,350,006	730,031	29,332	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.675339	2.385234	55.408988	14.405853	0.637444	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00
205.00	Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	EMPLOYEE BENEFITS (HOSPITAL SALARIES)	SHARED HUMAN RESOURCES (HOSP/NH GROSS SAL)	HOSPITAL ONLY BUS OFF AND A&G (HOSP ONLY ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL SHA (ACCUM. COST)	
		4.00	4.01	5.01	5A.02	5.02	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS	6,734,197					4.00
4.01	SHARED HUMAN RESOURCES	56,535	7,884,106				4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G	446,542	446,542	14,814,285			5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA	819,372	846,550	1,308,239	-1,491,211	17,823,934	5.02
7.00	OPERATION OF PLANT	114,437	114,437	713,895	0	813,741	7.00
7.01	OPERATION OF PLANT NURSING HOME	0	103,095	0	0	451,070	7.01
8.00	LAUNDRY & LINEN SERVICE	0	0	56,213	0	64,075	8.00
9.00	HOUSEKEEPING	79,574	79,574	163,505	0	186,373	9.00
9.01	HOUSEKEEPING NURSING HOME	0	96,643	0	0	120,384	9.01
10.00	DIETARY	77,909	77,909	200,963	0	229,070	10.00
11.00	CAFETERIA	75,624	75,624	139,076	0	158,527	11.00
13.00	NURSING ADMINISTRATION	97,466	97,466	153,437	0	174,897	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	135,355	135,355	292,732	0	333,674	16.00
17.00	SOCIAL SERVICE	18,932	18,932	36,798	0	41,945	17.00
19.00	NONPHYSICIAN ANESTHETISTS	345,458	345,458	445,606	0	507,929	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,108,055	1,108,055	2,087,287	0	2,379,212	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	125,619	125,619	176,617	0	201,318	43.00
46.00	OTHER LONG TERM CARE	0	973,414	0	0	1,828,018	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	250,840	250,840	682,579	0	778,045	50.00
52.00	DELIVERY ROOM & LABOR ROOM	66,152	66,152	146,591	0	167,094	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	403,538	403,538	1,345,869	0	1,534,104	54.00
56.00	RADIOISOTOPE	0	0	91,081	0	103,820	56.00
60.00	LABORATORY	337,265	337,265	1,310,980	0	1,494,335	60.00
60.02	GEO PSYCH	63,011	63,011	338,778	0	386,160	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	74,863	0	85,333	62.00
65.00	RESPIRATORY THERAPY	143,140	143,140	284,004	0	323,725	65.00
66.00	PHYSICAL THERAPY	0	0	65,838	0	75,046	66.00
69.00	ELECTROCARDIOLOGY	7,315	7,315	90,055	0	102,650	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,665	30,665	384,100	0	437,821	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	10,259	0	11,694	72.00
73.00	DRUGS CHARGED TO PATIENTS	128,399	128,399	731,112	0	833,366	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	145,405	145,405	255,384	0	291,102	88.00
88.01	RURAL HEALTH CLINIC II	446,798	446,798	764,176	0	871,054	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	436,879	436,879	747,361	0	851,888	90.00
91.00	EMERGENCY	548,305	548,305	1,352,684	0	1,541,872	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
93.01	DIABETIC EDUCATION	36,906	36,906	52,559	0	59,910	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,545,496	7,689,291	14,502,641	-1,491,211	17,439,252	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,166	0	5,889	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	188,701	188,701	306,478	0	349,342	192.00
194.00	NAUVOO APARTMENTS	0	0	0	0	21,213	194.00
194.02	BEAUTY SHOP	0	6,114	0	0	8,238	194.02
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)	1,651,843	98,604	2,071,937		1,491,211	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.245292	0.012507	0.139861		0.083663	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	772,163		81,583	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.052123		0.004577	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT NURSING HOME (NH/MSS SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOSP ONLY SQUARE FT)	HOUSEKEEPING NURSING HOME (NH/MSS SQUARE FEET)	
		7.00	7.01	8.00	9.00	9.01	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS						4.00
4.01	SHARED HUMAN RESOURCES						4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA						5.02
7.00	OPERATION OF PLANT	30,123					7.00
7.01	OPERATION OF PLANT NURSING HOME	0	42,255				7.01
8.00	LAUNDRY & LINEN SERVICE	182	0	79,452			8.00
9.00	HOUSEKEEPING	456	0	0	29,485		9.00
9.01	HOUSEKEEPING NURSING HOME	0	293	0	0	41,962	9.01
10.00	DIETARY	862	0	0	862	0	10.00
11.00	CAFETERIA	491	0	1,543	491	0	11.00
13.00	NURSING ADMINISTRATION	265	0	0	265	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	787	1,952	0	787	1,952	16.00
17.00	SOCIAL SERVICE	175	0	0	175	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,782	0	37,797	9,782	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	225	0	0	225	0	43.00
46.00	OTHER LONG TERM CARE	0	31,598	0	0	31,598	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,007	0	14,035	4,007	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	886	0	0	886	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,429	0	11,547	4,429	0	54.00
56.00	RADIOISOTOPE	310	0	0	310	0	56.00
60.00	LABORATORY	1,688	0	606	1,688	0	60.00
60.02	GEO PSYCH	0	0	0	0	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	691	1,486	1,836	691	1,486	65.00
66.00	PHYSICAL THERAPY	259	492	0	259	492	66.00
69.00	ELECTROCARDIOLOGY	1,125	0	0	1,125	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	326	1,956	0	326	1,956	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,251	1,160	0	1,251	1,160	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	234	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	1,101	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	1,378	0	0	90.00
91.00	EMERGENCY	1,852	0	9,152	1,852	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
93.01	DIABETIC EDUCATION	0	0	0	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	30,049	38,937	79,229	29,411	38,644	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	74	0	0	74	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,076	0	0	3,076	192.00
194.00	NAUVOO APARTMENTS	0	0	223	0	0	194.00
194.02	BEAUTY SHOP	0	242	0	0	242	194.02
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)	881,821	488,808	74,764	215,315	133,845	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	29.274010	11.568051	0.940996	7.302527	3.189672	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	195,149	14,652	17,108	44,164	1,352	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6.478405	0.346752	0.215325	1.497846	0.032220	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		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	NEW CAP REL COSTS-NH BLDG						1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-NH ME						2.01
4.00	EMPLOYEE BENEFITS						4.00
4.01	SHARED HUMAN RESOURCES						4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA						5.02
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT NURSING HOME						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
9.01	HOUSEKEEPING NURSING HOME						9.01
10.00	DIETARY	2,555					10.00
11.00	CAFETERIA	0	161,389				11.00
13.00	NURSING ADMINISTRATION	0	3,688	146,540			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	11,161	0	0	0	16.00
17.00	SOCIAL SERVICE	0	1,265	1,265	0	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	2,109	2,109	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,555	47,995	47,995	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	6,195	6,195	0	0	43.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	10,172	10,172	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	3,255	3,255	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	17,031	17,031	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	LABORATORY	0	18,867	18,867	0	0	60.00
60.02	GEO PSYCH	0	4,814	4,814	0	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	8,028	8,028	0	0	65.00
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	1,855	1,855	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,212	4,212	0	0	73.00
	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
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	19,108	19,108	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
93.01	DIABETIC EDUCATION	0	1,634	1,634	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,555	161,389	146,540	0	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	BEAUTY SHOP	0	0	0	0	0	194.02
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)	279,764	191,202	203,591	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	109.496673	1.184728	1.389320	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	78,579	46,502	30,477	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	30.754990	0.288136	0.207977	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/27/2012 3:39 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		16.00	17.00	19.00		
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	NEW CAP REL COSTS-NH BLDG					1.01
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	NEW CAP REL COSTS-NH ME					2.01
4.00	EMPLOYEE BENEFITS					4.00
4.01	SHARED HUMAN RESOURCES					4.01
5.01	HOSPITAL ONLY BUS OFF AND A&G					5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL SHA					5.02
7.00	OPERATION OF PLANT					7.00
7.01	OPERATION OF PLANT NURSING HOME					7.01
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
9.01	HOUSEKEEPING NURSING HOME					9.01
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	31,673,742				16.00
17.00	SOCIAL SERVICE	0	291			17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	2,080		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	2,874,577	284			30.00
31.00	INTENSIVE CARE UNIT	0	0			31.00
43.00	NURSERY	81,301	0			43.00
46.00	OTHER LONG TERM CARE	0	0			46.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	1,363,382	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	91,633	0	0		52.00
53.00	ANESTHESIOLOGY	1,105,458	0	2,080		53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,186,979	0	0		54.00
56.00	RADIOISOTOPE	513,897	0	0		56.00
60.00	LABORATORY	6,143,549	0	0		60.00
60.02	GEO PSYCH	519,464	0	0		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	121,408	0	0		62.00
65.00	RESPIRATORY THERAPY	640,221	0	0		65.00
66.00	PHYSICAL THERAPY	142,831	0	0		66.00
69.00	ELECTROCARDIOLOGY	373,415	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,156,211	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	1,663,656	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	425,113	0	0		88.00
88.01	RURAL HEALTH CLINIC II	1,100,149	0	0		88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	392,786	0	0		90.00
91.00	EMERGENCY	1,777,452	7	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	DIABETIC EDUCATION	25,871	0	0		93.01
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0	0	0		95.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	26,699,353	291	2,080		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	4,974,389	0	0		192.00
194.00	NAUVOO APARTMENTS	0	0	0		194.00
194.02	BEAUTY SHOP	0	0	0		194.02
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)	432,406	55,111	555,853		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.013652	189.384880	267.237019		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	101,941	16,351	26,598		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.003218	56.189003	12.787500		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/27/2012 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	3,467,962		3,467,962	0	0	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	NURSERY	243,447		243,447	0	0	43.00
46.00	OTHER LONG TERM CARE	2,447,272		2,447,272	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,047,704		1,047,704	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	223,110		223,110	0	0	52.00
53.00	ANESTHESIOLOGY	570,945		570,945	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,963,615		1,963,615	0	0	54.00
56.00	RADIOISOTOPE	130,861		130,861	0	0	56.00
60.00	LABORATORY	1,814,104		1,814,104	0	0	60.00
60.02	GEO PSYCH	437,950		437,950	0	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	94,129		94,129	0	0	62.00
65.00	RESPIRATORY THERAPY	429,145	0	429,145	0	0	65.00
66.00	PHYSICAL THERAPY	100,008	0	100,008	0	0	66.00
69.00	ELECTROCARDIOLOGY	157,484		157,484	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	535,800		535,800	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	12,672		12,672	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	999,518		999,518	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	321,480		321,480	0	0	88.00
88.01	RURAL HEALTH CLINIC II	959,984		959,984	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	929,819		929,819	0	0	90.00
91.00	EMERGENCY	1,821,998		1,821,998	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	525,171		525,171		0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	DIABETIC EDUCATION	69,481		69,481	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0		0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	19,303,659	0	19,303,659	0	0	200.00
201.00	Less Observation Beds	525,171		525,171		0	201.00
202.00	Total (see instructions)	18,778,488	0	18,778,488	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/27/2012 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	2,036,340		2,036,340			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
43.00	NURSERY	81,301		81,301			43.00
46.00	OTHER LONG TERM CARE	2,103,856		2,103,856			46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	276,067	1,087,315	1,363,382	0.768460	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	91,633	0	91,633	2.434822	0.000000	52.00
53.00	ANESTHESIOLOGY	185,402	920,056	1,105,458	0.516478	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	589,810	5,597,169	6,186,979	0.317379	0.000000	54.00
56.00	RADIOISOTOPE	25,184	488,713	513,897	0.254644	0.000000	56.00
60.00	LABORATORY	882,144	5,261,405	6,143,549	0.295286	0.000000	60.00
60.02	GEO PSYCH	0	519,464	519,464	0.843081	0.000000	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	49,280	72,128	121,408	0.775311	0.000000	62.00
65.00	RESPIRATORY THERAPY	210,018	430,203	640,221	0.670308	0.000000	65.00
66.00	PHYSICAL THERAPY	122,621	20,210	142,831	0.700184	0.000000	66.00
69.00	ELECTROCARDIOLOGY	28,049	345,366	373,415	0.421740	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	545,205	583,661	1,128,866	0.474636	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	27,345	27,345	0.463412	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	840,385	823,271	1,663,656	0.600796	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	425,113	425,113			88.00
88.01	RURAL HEALTH CLINIC II	0	1,100,149	1,100,149			88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	1,000	390,786	391,786	2.373283	0.000000	90.00
91.00	EMERGENCY	34,875	1,742,577	1,777,452	1.025062	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	28,105	810,132	838,237	0.626519	0.000000	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	DIABETIC EDUCATION	0	25,871	25,871	2.685671	0.000000	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	8,131,275	20,670,934	28,802,209			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,131,275	20,670,934	28,802,209			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/27/2012 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
31.00	INTENSIVE CARE UNIT			31.00
43.00	NURSERY			43.00
46.00	OTHER LONG TERM CARE			46.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	RADIOISOTOPE	0.000000		56.00
60.00	LABORATORY	0.000000		60.00
60.02	GEO PSYCH	0.000000		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
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
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC			88.00
88.01	RURAL HEALTH CLINIC II			88.01
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
93.01	DIABETIC EDUCATION	0.000000		93.01
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	0.000000		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part II Date/Time Prepared: 1/27/2012 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						
50.00	OPERATING ROOM	363,304	1,363,382	0.266473	52,783	14,065	50.00
52.00	DELIVERY ROOM & LABOR ROOM	79,239	91,633	0.864743	0	0	52.00
53.00	ANESTHESIOLOGY	3,557	1,105,458	0.003218	27,317	88	53.00
54.00	RADIOLOGY-DIAGNOSTIC	452,568	6,186,979	0.073148	352,333	25,772	54.00
56.00	RADIOISOTOPE	30,991	513,897	0.060306	13,122	791	56.00
60.00	LABORATORY	236,956	6,143,549	0.038570	426,144	16,436	60.00
60.02	GEO PSYCH	43,914	519,464	0.084537	0	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,684	121,408	0.038581	30,119	1,162	62.00
65.00	RESPIRATORY THERAPY	80,584	640,221	0.125869	122,199	15,381	65.00
66.00	PHYSICAL THERAPY	26,058	142,831	0.182439	26,074	4,757	66.00
69.00	ELECTROCARDIOLOGY	93,881	373,415	0.251412	15,444	3,883	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,678	1,128,866	0.051980	250,822	13,038	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	589	27,345	0.021540	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	151,242	1,663,656	0.090909	365,712	33,247	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	16,061	425,113	0.037781	0	0	88.00
88.01	RURAL HEALTH CLINIC II	47,595	1,100,149	0.043262	0	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	87,596	391,786	0.223581	17	4	90.00
91.00	EMERGENCY	239,196	1,777,452	0.134572	1,452	195	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	838,237	0.000000	665	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	DIABETIC EDUCATION	7,854	25,871	0.303583	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	2,024,547	24,580,712		1,684,203	128,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/27/2012 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						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	555,853	0	0	0	555,853	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.02	GEO PSYCH	0	0	0	0	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
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
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	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
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
93.01	DIABETIC EDUCATION	0	0	0	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	555,853	0	0	0	555,853	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/27/2012 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						
50.00	OPERATING ROOM	0	1,363,382	0.000000	0.000000	52,783	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	91,633	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	1,105,458	0.502826	0.000000	27,317	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	6,186,979	0.000000	0.000000	352,333	54.00
56.00	RADIOISOTOPE	0	513,897	0.000000	0.000000	13,122	56.00
60.00	LABORATORY	0	6,143,549	0.000000	0.000000	426,144	60.00
60.02	GEO PSYCH	0	519,464	0.000000	0.000000	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	121,408	0.000000	0.000000	30,119	62.00
65.00	RESPIRATORY THERAPY	0	640,221	0.000000	0.000000	122,199	65.00
66.00	PHYSICAL THERAPY	0	142,831	0.000000	0.000000	26,074	66.00
69.00	ELECTROCARDIOLOGY	0	373,415	0.000000	0.000000	15,444	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,128,866	0.000000	0.000000	250,822	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	27,345	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,663,656	0.000000	0.000000	365,712	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	425,113	0.000000	0.000000	0	88.00
88.01	RURAL HEALTH CLINIC II	0	1,100,149	0.000000	0.000000	0	88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	391,786	0.000000	0.000000	17	90.00
91.00	EMERGENCY	0	1,777,452	0.000000	0.000000	1,452	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	838,237	0.000000	0.000000	665	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	DIABETIC EDUCATION	0	25,871	0.000000	0.000000	0	93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	24,580,712			1,684,203	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/27/2012 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					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	13,736	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	RADIOISOTOPE	0	0	0		56.00
60.00	LABORATORY	0	0	0		60.00
60.02	GEO PSYCH	0	0	0		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
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
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	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
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
93.01	DIABETIC EDUCATION	0	0	0		93.01
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	13,736	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/27/2012 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						
50.00	OPERATING ROOM	0.768460	0	404,611	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	2.434822	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.516478	0	327,957	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.317379	0	2,003,894	0		54.00
56.00	RADIOISOTOPE	0.254644	0	233,839	0		56.00
60.00	LABORATORY	0.295286	0	1,983,104	0		60.00
60.02	GEO PSYCH	0.843081	0	504,401	0		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.775311	0	51,710	0		62.00
65.00	RESPIRATORY THERAPY	0.670308	0	158,697	0		65.00
66.00	PHYSICAL THERAPY	0.700184	0	11,817	0		66.00
69.00	ELECTROCARDIOLOGY	0.421740	0	158,884	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.474636	0	193,507	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.463412	0	18,219	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.600796	0	444,165	6,853		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
88.01	RURAL HEALTH CLINIC II	0.000000					88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	2.373283	0	70,211	0		90.00
91.00	EMERGENCY	1.025062	0	490,786	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.626519	0	373,148	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
93.01	DIABETIC EDUCATION	2.685671	0	6,965	0		93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.000000		0			95.00
200.00	Subtotal (see instructions)		0	7,435,915	6,853		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	7,435,915	6,853		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/27/2012 3:39 pm

Title XVIII | Hospital | 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					
50.00	OPERATING ROOM	0	310,927	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	169,383	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	635,994	0		54.00
56.00	RADIOISOTOPE	0	59,546	0		56.00
60.00	LABORATORY	0	585,583	0		60.00
60.02	GEO PSYCH	0	425,251	0		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	40,091	0		62.00
65.00	RESPIRATORY THERAPY	0	106,376	0		65.00
66.00	PHYSICAL THERAPY	0	8,274	0		66.00
69.00	ELECTROCARDIOLOGY	0	67,008	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	91,845	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	8,443	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	266,853	4,117		73.00
	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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	166,631	0		90.00
91.00	EMERGENCY	0	503,086	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	233,784	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	DIABETIC EDUCATION	0	18,706	0		93.01
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	3,697,781	4,117		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	3,697,781	4,117		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/27/2012 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						
50.00	OPERATING ROOM	0.768460	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	2.434822	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.516478	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.317379	0	0	0		54.00
56.00	RADIOISOTOPE	0.254644	0	0	0		56.00
60.00	LABORATORY	0.295286	0	0	0		60.00
60.02	GEO PSYCH	0.843081	0	0	0		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.775311	0	0	0		62.00
65.00	RESPIRATORY THERAPY	0.670308	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.700184	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0.421740	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.474636	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.463412	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.600796	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
88.01	RURAL HEALTH CLINIC II	0.000000					88.01
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	2.373283	0	0	0		90.00
91.00	EMERGENCY	1.025062	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.626519	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
93.01	DIABETIC EDUCATION	2.685671	0	0	0		93.01
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.000000		0			95.00
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: 141305 | Component CCN: 14Z305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/27/2012 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					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	RADIOISOTOPE	0	0	0		56.00
60.00	LABORATORY	0	0	0		60.00
60.02	GEO PSYCH	0	0	0		60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
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
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	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
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
93.01	DIABETIC EDUCATION	0	0	0		93.01
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
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: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/27/2012 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)	3,006	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,307	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)	2,307	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	334	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)	334	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	16	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)	15	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,120	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)	270	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)	269	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	118.65	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	119.84	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,467,962	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)	1,898	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)	1,798	25.00
26.00	Total swing-bed cost (see instructions)	781,555	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,686,407	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,118,055	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,118,055	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.268337	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)	918.10	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,686,407	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)	1,164.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,304,195	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,304,195	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/27/2012 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	766,414	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,070,609	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)	314,404	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	313,240	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	627,644	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)	451	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,164.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	525,171	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/27/2012 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: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/27/2012 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		958,612		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.768460	52,783	40,562	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2.434822	0	0	52.00
53.00	ANESTHESIOLOGY	0.516478	27,317	14,109	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.317379	352,333	111,823	54.00
56.00	RADIOISOTOPE	0.254644	13,122	3,341	56.00
60.00	LABORATORY	0.295286	426,144	125,834	60.00
60.02	GEO PSYCH	0.843081	0	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.775311	30,119	23,352	62.00
65.00	RESPIRATORY THERAPY	0.670308	122,199	81,911	65.00
66.00	PHYSICAL THERAPY	0.700184	26,074	18,257	66.00
69.00	ELECTROCARDIOLOGY	0.421740	15,444	6,513	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.474636	250,822	119,049	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.463412	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.600796	365,712	219,718	73.00
	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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.373283	17	40	90.00
91.00	EMERGENCY	1.025062	1,452	1,488	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.626519	665	417	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	DIABETIC EDUCATION	2.685671	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,684,203	766,414	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)		1,684,203		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/27/2012 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		233,334		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.768460	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2.434822	0	0	52.00
53.00	ANESTHESIOLOGY	0.516478	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.317379	12,482	3,962	54.00
56.00	RADIOISOTOPE	0.254644	0	0	56.00
60.00	LABORATORY	0.295286	35,473	10,475	60.00
60.02	GEO PSYCH	0.843081	0	0	60.02
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.775311	0	0	62.00
65.00	RESPIRATORY THERAPY	0.670308	18,386	12,324	65.00
66.00	PHYSICAL THERAPY	0.700184	78,028	54,634	66.00
69.00	ELECTROCARDIOLOGY	0.421740	572	241	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.474636	28,660	13,603	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.463412	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.600796	89,997	54,070	73.00
	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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.373283	0	0	90.00
91.00	EMERGENCY	1.025062	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.626519	133	83	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	DIABETIC EDUCATION	2.685671	0	0	93.01
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		263,731	149,392	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)		263,731		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/27/2012 3:39 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,701,898	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,701,898	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,738,917	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)	38,347	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,080,955	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,619,615	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,619,615	30.00
31.00	Primary payer payments	248	31.00
32.00	Subtotal (line 30 minus line 31)	2,619,367	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)	294,719	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	294,719	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	216,997	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,914,086	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,914,086	40.00
41.00	Interim payments	2,748,754	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)	165,332	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	37,338	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: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/27/2012 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		1,686,783		2,422,582	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	02/18/2011	75,368	02/18/2011	266,857	3.01
3.02		05/20/2011	142,968	05/20/2011	59,315	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		218,336		326,172	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,905,119		2,748,754	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		2,238		165,332	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,907,357		2,914,086	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: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/27/2012 3:39 pm

Component CCN: 14Z305 | 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		720,094		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	02/18/2011	31,640		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	05/20/2011	66,297		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-34,657		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)		685,437		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		85,931		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		771,368		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: 141305 Component CCN: 14Z305	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2 Date/Time Prepared: 1/27/2012 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)	633,920	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)	150,886	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	539	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)	784,806	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	784,806	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)	784,806	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	13,438	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)	771,368	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)	771,368	0	19.00
20.00	Interim payments	685,437	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)	85,931	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	7,837	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/27/2012 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	2,070,609	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,070,609	4.00
5.00	Primary payer payments	7,355	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)	2,083,960	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,083,960	19.00
20.00	Deductibles (exclude professional component)	232,110	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)	1,851,850	22.00
23.00	Coinsurance	7,358	23.00
24.00	Subtotal (line 22 minus line 23)	1,844,492	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	62,865	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	62,865	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	53,845	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))	1,907,357	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,907,357	30.00
31.00	Interim payments	1,905,119	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)	2,238	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	20,904	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G | Date/Time Prepared: 1/27/2012 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	269,665	0	0	0	1.00
2.00	Temporary investments	97,012	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,388,017	0	0	0	4.00
5.00	Other receivable	1,005,152	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-770,000	0	0	0	6.00
7.00	Inventory	230,154	0	0	0	7.00
8.00	Prepaid expenses	162,811	0	0	0	8.00
9.00	Other current assets	0	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)	4,382,811	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	521,757	0	0	0	12.00
13.00	Land improvements	347,356	0	0	0	13.00
14.00	Accumulated depreciation	-167,720	0	0	0	14.00
15.00	Buildings	22,802,031	0	0	0	15.00
16.00	Accumulated depreciation	-4,420,513	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,541,785	0	0	0	23.00
24.00	Accumulated depreciation	-3,794,868	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	137,267	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,967,095	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,574,672	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	2,334,924	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,909,596	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,259,502	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,253,596	0	0	0	37.00
38.00	Salaries, wages, and fees payable	475,490	0	0	0	38.00
39.00	Payroll taxes payable	192,044	0	0	0	39.00
40.00	Notes and loans payable (short term)	504,979	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	103,590	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,529,699	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	20,460,458	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	20,460,458	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	22,990,157	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	15,269,345				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)	15,269,345	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,259,502	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/27/2012 3:39 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		15,465,491		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-472,033				2.00
3.00	Total (sum of line 1 and line 2)		14,993,458		0		3.00
4.00	CONTRIBUTIONS	41,031		0			4.00
5.00	UNREALIZED GAINS AND LOSS	221,116		0			5.00
6.00	RESTRICTED CONTRIBUTION	13,740		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)		275,887		0		10.00
11.00	Subtotal (line 3 plus line 10)		15,269,345		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)		15,269,345		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/27/2012 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	CONTRIBUTIONS	0		0			4.00
5.00	UNREALIZED GAINS AND LOSS	0		0			5.00
6.00	RESTRICTED CONTRIBUTION	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: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 1/27/2012 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	2,118,055		2,118,055	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	2,103,856		2,103,856	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,221,911		4,221,911	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	4,221,911		4,221,911	17.00
18.00	Ancillary services	3,918,683	0	3,918,683	18.00
19.00	Outpatient services	0	23,836,754	23,836,754	19.00
20.00	RURAL HEALTH CLINIC	0	425,113	425,113	20.00
20.01	RURAL HEALTH CLINIC II	0	1,100,149	1,100,149	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	274,988	274,988	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,140,594	25,637,004	33,777,598	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,430,302		29.00
30.00	BAD DEBTS	891,232			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		891,232		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,321,534		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141305	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/27/2012 3:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,777,598	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,430,580	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,347,018	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,321,534	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,974,516	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	12,791	6.00
7.00	Income from investments	706,599	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	18,612	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	174,023	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	3,898	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	145,132	22.00
23.00	Governmental appropriations	43,975	23.00
24.00	HOSPITAL OTHER INCOME	36,682	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	186,696	24.01
24.02	NURSING HOME OTHER INCOME	54,117	24.02
24.03	NAUVOO APARTMENTS	37,203	24.03
24.04	GAIN ON DISPOSAL	1,704	24.04
24.05	SALARY REIMBURSEMENTS	81,051	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	1,502,483	25.00
26.00	Total (line 5 plus line 25)	-472,033	26.00
27.00		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)	-472,033	29.00

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

Provider CCN: 141305 | Component CCN: 143456 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-1 | Date/Time Prepared: 1/27/2012 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	0	0	0	0	0	1.00
2.00	Physician Assistant	93,693	0	93,693	0	93,693	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	69,450	0	69,450	-17,738	51,712	9.00
10.00	Subtotal (sum of lines 1-9)	163,143	0	163,143	-17,738	145,405	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	30,000	30,000	0	30,000	12.00
13.00	Other Costs Under Agreement	0	66	66	0	66	13.00
14.00	Subtotal (sum of lines 11-13)	0	30,066	30,066	0	30,066	14.00
15.00	Medical Supplies	0	11,721	11,721	0	11,721	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	2,560	2,560	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	22,515	22,515	0	22,515	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	34,236	34,236	2,560	36,796	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	163,143	64,302	227,445	-15,178	212,267	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	8,375	8,375	0	8,375	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	8,375	8,375	0	8,375	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	163,143	72,677	235,820	-15,178	220,642	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 1/27/2012 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	0		1.00
2.00	Physician Assistant	0	93,693		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	51,712		9.00
10.00	Subtotal (sum of lines 1-9)	0	145,405		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	30,000		12.00
13.00	Other Costs Under Agreement	0	66		13.00
14.00	Subtotal (sum of lines 11-13)	0	30,066		14.00
15.00	Medical Supplies	0	11,721		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	2,560		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	22,515		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	36,796		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	212,267		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	-2,744	5,631		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,744	5,631		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,744	217,898		32.00

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

Provider CCN: 141305 | Component CCN: 143405 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-1 | Date/Time Prepared: 1/27/2012 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	276,131	0	276,131	-64,535	211,596	1.00
2.00	Physician Assistant	184,236	0	184,236	-18,424	165,812	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	90,391	0	90,391	-21,002	69,389	9.00
10.00	Subtotal (sum of lines 1-9)	550,758	0	550,758	-103,961	446,797	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	51,298	51,298	0	51,298	12.00
13.00	Other Costs Under Agreement	0	7,624	7,624	0	7,624	13.00
14.00	Subtotal (sum of lines 11-13)	0	58,922	58,922	0	58,922	14.00
15.00	Medical Supplies	0	34,396	34,396	0	34,396	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	19,249	19,249	0	19,249	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	53,645	53,645	0	53,645	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	550,758	112,567	663,325	-103,961	559,364	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	106,346	106,346	289	106,635	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	106,346	106,346	289	106,635	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	550,758	218,913	769,671	-103,672	665,999	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141305 Component CCN: 143405	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 1/27/2012 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	211,596		1.00
2.00	Physician Assistant	0	165,812		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	69,389		9.00
10.00	Subtotal (sum of lines 1-9)	0	446,797		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	51,298		12.00
13.00	Other Costs Under Agreement	0	7,624		13.00
14.00	Subtotal (sum of lines 11-13)	0	58,922		14.00
15.00	Medical Supplies	0	34,396		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	19,249		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	53,645		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	559,364		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	-10,632	-10,632		29.00
30.00	Administrative Costs	-6,375	100,260		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-17,007	89,628		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-17,007	648,992		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141305 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-2

Component CCN: 143456 | Date/Time Prepared: 1/27/2012 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	1.00	3,376	2,100	2,100		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	1.00	3,376		2,100	3,376	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)	1.00	3,376			3,376	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)					212,267	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)					212,267	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)					5,631	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					103,582	15.00
16.00	Total overhead (sum of lines 14 and 15)					109,213	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					109,213	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					109,213	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					321,480	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES	Provider CCN: 141305 Component CCN: 143405	Period: From 07/01/2010 To 06/30/2011	Worksheet M-2 Date/Time Prepared: 1/27/2012 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	0.72	1,676	4,200	3,024		1.00
2.00	Physician Assistant	0.90	1,863	2,100	1,890		2.00
3.00	Nurse Practitioner	0.90	2,342	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1-3)	2.52	5,881		6,804	6,804	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)	2.52	5,881			6,804	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)					559,364	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)					559,364	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)					89,628	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					310,992	15.00
16.00	Total overhead (sum of lines 14 and 15)					400,620	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					400,620	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					400,620	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					959,984	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 1/27/2012 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)		321,480	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		4,307	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		317,173	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,376	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)		3,376	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		93.95	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)	76.84	77.76	8.00
9.00	Rate for Program covered visits (see instructions)	93.95	93.95	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	695	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	65,295	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) *	0	65,295	16.00
16.01	Total program charges (see instructions)(from contractor's records)		46,620	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,967	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		6,957	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		39,149	16.04
16.05	Total program cost (see instructions)	0	46,106	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,402	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		46,106	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,923	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		48,029	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)		48,029	26.00
27.00	Interim payments		48,510	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)		-481	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		542	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141305 Component CCN: 143405	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 1/27/2012 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)		959,984	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		2,983	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		957,001	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		6,804	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)		6,804	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		140.65	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)	76.84	77.76	8.00
9.00	Rate for Program covered visits (see instructions)	140.65	140.65	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	377	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	53,025	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) *	0	53,025	16.00
16.01	Total program charges (see instructions)(from contractor's records)		23,010	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,100	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,144	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		32,689	16.04
16.05	Total program cost (see instructions)	0	39,833	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,020	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		39,833	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		153	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		39,986	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)		39,986	26.00
27.00	Interim payments		46,766	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)		-6,780	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		430	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2010 To 06/30/2011	Worksheet M-4 Date/Time Prepared: 1/27/2012 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)	145,405	145,405	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001247	0.004625	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	181	672	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,137	854	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,318	1,526	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	212,267	212,267	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	109,213	109,213	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006209	0.007189	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	678	785	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,996	2,311	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	24	89	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	83.17	25.97	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	10	42	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	832	1,091	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)		4,307	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)		1,923	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141305 Component CCN: 143405	Period: From 07/01/2010 To 06/30/2011	Worksheet M-4 Date/Time Prepared: 1/27/2012 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)	446,797	446,797	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000186	0.001118	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	83	500	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	521	634	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	604	1,134	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	559,364	559,364	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	400,620	400,620	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001080	0.002027	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	433	812	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,037	1,946	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	11	66	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	94.27	29.48	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	2	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	94	59	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)		2,983	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)		153	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 1/27/2012 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		50,242	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		02/18/2011	1,732	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)		-1,732	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		48,510	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		481	6.02
7.00	Total Medicare program liability (see instructions)		48,029	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: 141305 Component CCN: 143405	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 1/27/2012 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		55,981	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		02/18/2011	9,215	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)		-9,215	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		46,766	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		6,780	6.02
7.00	Total Medicare program liability (see instructions)		39,986	7.00

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