

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).		FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011 Worksheet S Parts I-III Date/Time Prepared: 5/22/2012 5:55 pm

PART I - COST REPORT STATUS		
Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/22/2012 Time: 5:55 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 04 12. <input type="checkbox"/> 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 PARIS COMMUNITY HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	104,097	84,288	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	18,017	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		197,122		0	10.00
10.01 RURAL HEALTH CLINIC II II	0		2,071		0	10.01
10.02 RURAL HEALTH CLINIC III III	0		3,391		0	10.02
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	122,114	286,872	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141320			Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 3:48 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 721 EAST COURT STREET			PO Box:						1.00	
2.00	City: PARIS			State: IL		Zip Code: 61944-		County: EDGAR		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		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		PARI S COMMUNI TY HOSPI TAL	141320	14999	1	06/30/2002	N	0	N	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		PARI S COMMUNI TY HOSPI TAL	14Z320	14999		06/30/2002	N	0	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		FMC	143987	14999		09/24/1994	N	0	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1		HATCH	143989	14999		01/01/1995	N	0	N	15.01
15.02	Hospital-Based Health Clinic - RHC 2		FMC	143431	14999		02/16/1997	N	0	N	15.02
16.00	Hospital-Based Health Clinic - FOHC										16.00
17.00	Hospital-Based (CMHC) 1										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2011	12/31/2011		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						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	
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						1				26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).						1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0				35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 3:48 pm		
		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	
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 1.00	XVIII 2.00	XIX 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.				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 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	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. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-2
Part I
Date/Time Prepared:
5/22/2012 3:48 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	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 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
70.00	Inpatient Psychiatric Facility PPS 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 3:48 pm	
			1.00	2.00	3.00
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
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)(i)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	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)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
			Respiratory		4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	109.00
			1.00		2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			0	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			0	0119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00

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		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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	N		N		158.00	
159.00	SNF	N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		160.00	
161.00	CMHC	N		N		161.00	
						1.00	
Multi campus							
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	
						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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/22/2012 3:48 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
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	C	05/20/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
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		Legal Oper.	
		1.00		2.00	
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	03/31/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-2
Part II
Date/Time Prepared:
5/22/2012 3:48 pm

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
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	03/31/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2012 3:48 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	30,624.00		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)		25	9,125	30,624.00		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	30,624.00		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						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
26.02 RURAL HEALTH CLINIC III	88.02					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				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: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2012 3:48 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	841	149	1,276		1.00
2.00 HMO		18	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	633	0	633		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		3,424	3,424		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,474	3,573	5,333		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0	1,474	3,573	5,333		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						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	9,590	0	43,087		26.00
26.01 RURAL HEALTH CLINIC II	0	376	0	2,170		26.01
26.02 RURAL HEALTH CLINIC III	0	106	0	805		26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	219		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2012 3:48 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	282	1.00
2.00 HMO					7	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	169.11	0.00	0	282	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	53.72	0.00			26.00
26.01 RURAL HEALTH CLINIC II	0.00	2.91	0.00			26.01
26.02 RURAL HEALTH CLINIC III	0.00	1.21	0.00			26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	226.95	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: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet S-3
Part I
Date/Time Prepared:
5/22/2012 3:48 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)	60	461		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)	60	461		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.01 RURAL HEALTH CLINIC II				26.01
26.02 RURAL HEALTH CLINIC III				26.02
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

HOSPITAL WAGE RELATED COSTS	Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part IV Date/Time Prepared: 5/22/2012 3:48 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	387,393	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	2,433,087	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	72,374	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	79,517	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	104,367	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	874,941	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	29,703	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	9,151	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,990,533	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm
			Rural Health Clinic (RHC) I	Cost
				1.00
1.00	Clinic Address and Identification Street	727 EAST COURT STREET		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	PARI S	IL	61944
				1.00
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
		Grant Award	Date	
		1.00	2.00	
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
				1.00
				2.00
10.00	Does this facility operate as other than an RHC or FOHC? 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
				1.00
				2.00
				3.00
				4.00
11.00	Facility hours of operations (1) 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
				1.00
				2.00
14.00	Provider name, CCN number			14.00
				1.00
				2.00
				3.00
				4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)	N	0	0
				15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm
			Rural Health Clinic (RHC) I	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	EDGAR		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00
				19:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm		
			Rural Health Clinic (RHC) I	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	08:00	19:00	08:00	19:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm Cost
		Rural Health Clinic (RHC) I	

		Saturday			
		from	to		
11.00	Facility hours of operations (1) Clinic	08:00	11:30		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm
			Rural Health Clinic (RHC) II	Cost
				1.00
1.00	Clinic Address and Identification			
	Street	144 ILLINOIS		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County		CHRI SMAN	IL61924
				2.00
				1.00
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
				3.00
				1.00
				2.00
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)			0
5.00	Migrant Health Center (Section 329(d), PHS Act)			0
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0
7.00	Appalachian Regional Commission			0
8.00	Look-Alikes			0
9.00	OTHER (SPECIFY)			0
				4.00
				5.00
				6.00
				7.00
				8.00
				9.00
				1.00
				2.00
10.00	Does this facility operate as other than an RHC or FOHC? 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
		1.00	2.00	3.00
				4.00
11.00	Facility hours of operations (1)			
	Clinic	08:00	12:00	
				11.00
				1.00
				2.00
12.00	Have you received an approval for an exception to the productivity standard?			N
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
				12.00
				13.00
			Provider name	CCN number
			1.00	2.00
14.00	Provider name, CCN number			
				14.00
		Y/N	V	XVIII
		1.00	2.00	3.00
				XIX
				4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		N	0
				0
				0
				0
				15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm
			Rural Health Clinic (RHC) II	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	EDGAR		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	13:30	19:30	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm		
			Rural Health Clinic (RHC) II	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	08:00	12:00	08:00	12:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm
		Rural Health Clinic (RHC) II	Cost

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143431	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm	
			Rural Health Clinic (RHC) III	Cost	
				1.00	
1.00	Clinic Address and Identification				
	Street	104 BUENA VISTA		1.00	
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	KANSAS IL61933		2.00	
				1.00	
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
			Grant Award	Date	
			1.00	2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0 4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			0 5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0 6.00	
7.00	Appalachian Regional Commission			0 7.00	
8.00	Look-Alikes			0 8.00	
9.00	OTHER (SPECIFY)			0 9.00	
			1.00	2.00	
10.00	Does this facility operate as other than an RHC or FOHC? 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		
11.00	Facility hours of operations (1)				
	Clinic	08:30	12:00	11.00	
			1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N 12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N 0 13.00	
			Provider name	CCN number	
			1.00	2.00	
14.00	Provider name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		N 0	0 0 0 15.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143431	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm
			Rural Health Clinic (RHC) III	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	EDGAR		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:30	12:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141320 Component CCN: 143431	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm Cost
		Rural Health Clinic (RHC) III	

	Thursday		Friday		
	from	to	from	to	
	9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	13:30	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141320 Component CCN: 143431	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/22/2012 3:48 pm
		Rural Health Clinic (RHC) III	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/22/2012 3:48 pm
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			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)		0.468094	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,789,676	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?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		13,225,885	6.00	
7.00	Medicaid cost (line 1 times line 6)		6,190,957	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)		2,401,281	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,401,281	19.00	
			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	2,287,049	0	2,287,049	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,070,554	0	1,070,554	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,070,554	0	1,070,554	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)		4,056,613	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		850,577	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		3,206,036	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,500,726	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,571,280	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,972,561	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 141320		Period: From 01/01/2011 To 12/31/2011		Worksheet A	
Date/Time Prepared: 5/22/2012 3:48 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		1,072,072	1,072,072	237,168	1,309,240	1.00	
2.00 NEW CAP REL COSTS-MVBLE EQUIP		710,471	710,471	155,626	866,097	2.00	
4.00 EMPLOYEE BENEFITS	143,196	4,136,180	4,279,376	-305,413	3,973,963	4.00	
5.01 OTHER ADMINISTRATIVE AND GENERAL	1,013,066	2,794,012	3,807,078	-131,424	3,675,654	5.01	
5.02 ADMITTING	504,423	147,633	652,056	-873	651,183	5.02	
7.00 OPERATION OF PLANT	348,119	553,020	901,139	-364	900,775	7.00	
8.00 LAUNDRY & LINEN SERVICE	0	112,728	112,728	0	112,728	8.00	
9.00 HOUSEKEEPING	194,013	42,320	236,333	0	236,333	9.00	
10.00 DIETARY	355,241	178,840	534,081	-288,386	245,695	10.00	
11.00 CAFETERIA	0	0	0	288,386	288,386	11.00	
13.00 NURSING ADMINISTRATION	450,769	19,841	470,610	0	470,610	13.00	
15.00 PHARMACY	209,321	767,858	977,179	-751,915	225,264	15.00	
16.00 MEDICAL RECORDS & LIBRARY	298,193	63,727	361,920	0	361,920	16.00	
17.00 SOCIAL SERVICE	0	45,067	45,067	0	45,067	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	1,196,447	146,593	1,343,040	-20,419	1,322,621	30.00	
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	519,854	372,380	892,234	-253,407	638,827	50.00	
53.00 ANESTHESIOLOGY	495,097	35,939	531,036	146,179	677,215	53.00	
54.00 RADIOLOGY-DIAGNOSTIC	1,238,647	731,163	1,969,810	100,595	2,070,405	54.00	
60.00 LABORATORY	630,564	671,167	1,301,731	-464	1,301,267	60.00	
65.00 RESPIRATORY THERAPY	171,298	23,592	194,890	-29,295	165,595	65.00	
66.00 PHYSICAL THERAPY	670,591	52,453	723,044	0	723,044	66.00	
69.00 ELECTROCARDIOLOGY	0	39,880	39,880	47,023	86,903	69.00	
70.00 ELECTROENCEPHALOGRAPHY	0	96,851	96,851	0	96,851	70.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	302,957	302,957	71.00	
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00	
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	809,371	809,371	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	3,236,269	662,909	3,899,178	-26,891	3,872,287	88.00	
88.01 RURAL HEALTH CLINIC II	202,062	83,143	285,205	-29,046	256,159	88.01	
88.02 RURAL HEALTH CLINIC III	107,828	42,521	150,349	-16,672	133,677	88.02	
90.00 CLINIC	85,164	36,454	121,618	-15,060	106,558	90.00	
90.01 OP CLINIC	288,816	53,620	342,436	0	342,436	90.01	
90.02 SENIOR CARE	7,896	379,930	387,826	-22,800	365,026	90.02	
91.00 EMERGENCY	1,116,684	1,556,346	2,673,030	0	2,673,030	91.00	
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
SPECIAL PURPOSE COST CENTERS							
113.00 INTEREST EXPENSE		185,833	185,833	-185,833	0	113.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	13,483,558	15,814,543	29,298,101	9,043	29,307,144	118.00	
NONREIMBURSABLE COST CENTERS							
192.00 PHYSICIANS' PRIVATE OFFICES	893,981	201,143	1,095,124	-9,043	1,086,081	192.00	
200.00 TOTAL (SUM OF LINES 118-199)	14,377,539	16,015,686	30,393,225	0	30,393,225	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A
Date/Time Prepared:
5/22/2012 3:48 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	-208,554	1,100,686	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	866,097	2.00
4.00	EMPLOYEE BENEFITS	0	3,973,963	4.00
5.01	OTHER ADMINISTRATIVE AND GENERAL	-798,157	2,877,497	5.01
5.02	ADMINISTRATIVE	0	651,183	5.02
7.00	OPERATION OF PLANT	0	900,775	7.00
8.00	LAUNDRY & LINEN SERVICE	0	112,728	8.00
9.00	HOUSEKEEPING	0	236,333	9.00
10.00	DIETARY	0	245,695	10.00
11.00	CAFETERIA	-85,353	203,033	11.00
13.00	NURSING ADMINISTRATION	0	470,610	13.00
15.00	PHARMACY	0	225,264	15.00
16.00	MEDICAL RECORDS & LIBRARY	-7,026	354,894	16.00
17.00	SOCIAL SERVICE	0	45,067	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-85,386	1,237,235	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	638,827	50.00
53.00	ANESTHESIOLOGY	-657,195	20,020	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-750,625	1,319,780	54.00
60.00	LABORATORY	0	1,301,267	60.00
65.00	RESPIRATORY THERAPY	0	165,595	65.00
66.00	PHYSICAL THERAPY	0	723,044	66.00
69.00	ELECTROCARDIOLOGY	-38,857	48,046	69.00
70.00	ELECTROENCEPHALOGRAPHY	-96,537	314	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-65	302,892	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	-32,759	776,612	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-136,538	3,735,749	88.00
88.01	RURAL HEALTH CLINIC II	-3,479	252,680	88.01
88.02	RURAL HEALTH CLINIC III	-1,209	132,468	88.02
90.00	CLINIC	-16,229	90,329	90.00
90.01	OP CLINIC	-13,502	328,934	90.01
90.02	SENIOR CARE	-3,404	361,622	90.02
91.00	EMERGENCY	-1,176,339	1,496,691	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-4,111,214	25,195,930	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	-11,974	1,074,107	192.00
200.00	TOTAL (SUM OF LINES 118-199)	-4,123,188	26,270,037	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	155,626	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	155,626	
B - CAFETERIA					
1.00	CAFETERIA	11.00	191,818	96,568	1.00
	TOTALS		191,818	96,568	
C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	31,963	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		31,963	0	
D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	51,335	1.00
	TOTALS		0	51,335	
E - OXYGEN/PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	73,474	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	73,474	
F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	809,371	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	809,371	
H - TELEPHONE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	38,952	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	38,952	
I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	10,546	4,514	1.00
	TOTALS		10,546	4,514	
J - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	229,483	1.00
	TOTALS		0	229,483	
K - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	185,833	1.00
	TOTALS		0	185,833	
L - ANESTHESIA BENEFITS					
1.00	ANESTHESIOLOGY	53.00	0	147,362	1.00
	TOTALS		0	147,362	
M - RADIOLOGY BENEFITS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	154,954	1.00
	TOTALS		0	154,954	
N - WOUND CARE BENEFITS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,097	1.00
	TOTALS		0	3,097	
500.00	Grand Total: Increases		234,327	1,950,569	500.00

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - RENTAL EXPENSE							
1.00		0.00	0	0	0	10	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	56,972	0	0	2.00
3.00	ADMINISTRATIVE	5.02	0	873	0	0	3.00
4.00	OPERATION OF PLANT	7.00	0	364	0	0	4.00
8.00	ADULTS & PEDIATRICS	30.00	0	3,005	0	0	8.00
9.00	OPERATING ROOM	50.00	0	23,924	0	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	1,183	0	0	10.00
12.00	LABORATORY	60.00	0	464	0	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	3,341	0	0	13.00
14.00	SENIOR CARE	90.02	0	22,800	0	0	14.00
16.00	RURAL HEALTH CLINIC	88.00	0	9,718	0	0	16.00
17.00	RURAL HEALTH CLINIC II	88.01	0	18,393	0	0	17.00
18.00	RURAL HEALTH CLINIC III	88.02	0	6,928	0	0	18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,661	0	0	19.00
	TOTALS		0	155,626			
B - CAFETERIA							
1.00	DIETARY	10.00	191,818	96,568	0	0	1.00
	TOTALS		191,818	96,568			
C - EKG							
1.00	ADULTS & PEDIATRICS	30.00	17,414	0	0	0	1.00
2.00	RESPIRATORY THERAPY	65.00	14,549	0	0	0	2.00
	TOTALS		31,963	0			
D - PROPERTY INSURANCE							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	51,335	0	9	1.00
	TOTALS		0	51,335			
E - OXYGEN/PATIENT SUPPLIES							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	62,069	0	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	11,405	0	0	2.00
	TOTALS		0	73,474			
F - DRUGS							
1.00	PHARMACY	15.00	0	751,915	0	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	57,456	0	0	2.00
	TOTALS		0	809,371			
H - TELEPHONE							
1.00		0.00	0	0	0	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	17,173	0	0	2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	10,653	0	0	3.00
4.00	RURAL HEALTH CLINIC III	88.02	0	9,744	0	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,382	0	0	5.00
	TOTALS		0	38,952			
I - STRESS TEST							
1.00	CLINIC	90.00	10,546	4,514	0	0	1.00
	TOTALS		10,546	4,514			
J - MED SUPPLIES							
1.00	OPERATING ROOM	50.00	0	229,483	0	0	1.00
	TOTALS		0	229,483			
K - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	185,833	0	9	1.00
	TOTALS		0	185,833			
L - ANESTHESIA BENEFITS							
1.00	EMPLOYEE BENEFITS	4.00	0	147,362	0	0	1.00
	TOTALS		0	147,362			
M - RADIOLOGY BENEFITS							
1.00	EMPLOYEE BENEFITS	4.00	0	154,954	0	0	1.00
	TOTALS		0	154,954			
N - WOUND CARE BENEFITS							
1.00	EMPLOYEE BENEFITS	4.00	0	3,097	0	0	1.00
	TOTALS		0	3,097			
500.00	Grand Total: Decreases		234,327	1,950,569			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/22/2012 3:48 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	39,160	0	0	0	1.00
2.00	Land Improvements	1,815,667	12,259	0	12,259	2.00
3.00	Buildings and Fixtures	21,328,212	327,115	0	327,115	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	9,410,934	2,262,911	0	2,262,911	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,593,973	2,602,285	0	2,602,285	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,593,973	2,602,285	0	2,602,285	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	1,072,072	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	710,471	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,782,543	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL 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	0	0	0	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/22/2012 3:48 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	39,160	0		1.00		
2.00	Land Improvements	1,827,926	0		2.00		
3.00	Buildings and Fixtures	21,655,327	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	11,529,947	0		5.00		
6.00	Movable Equipment	0	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	35,052,360	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	35,052,360	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,072,072		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	710,471		2.00		
3.00	Total (sum of lines 1-2)	0	1,782,543		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL 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	1,100,686	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	710,471	155,626	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,811,157	155,626	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/22/2012 3:48 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	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	1,100,686	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	866,097	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,966,783	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8

Date/Time Prepared:
5/22/2012 3:48 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-66,387	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-7,130	OTHER ADMINISTRATIVE AND GENERAL	5.01 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		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	-1,449,021		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	398		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-85,353	CAFETERIA	11.00 14.00
15.00 Rental of quarters to employee and others	B	-76,645	NEW CAP REL COSTS-BLDG & FIXT	1.00 15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-65	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 16.00
17.00 Sale of drugs to other than patients	B	-32,759	DRUGS CHARGED TO PATIENTS	73.00 17.00
18.00 Sale of medical records and abstracts	B	-7,026	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines		0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant		0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0		0.00 32.00
33.00 PHYSICIAN RECRUITING	A	-66,153	OTHER ADMINISTRATIVE AND GENERAL	5.01 33.00
34.00 ADVERTISING	A	-41,998	OTHER ADMINISTRATIVE AND GENERAL	5.01 34.00
35.00		0		0.00 35.00
36.00 ADVERTISING	A	-30,676	RURAL HEALTH CLINIC	88.00 36.00
37.00 ADVERTISING	A	-3,479	RURAL HEALTH CLINIC II	88.01 37.00
38.00 ADVERTISING	A	-1,209	RURAL HEALTH CLINIC III	88.02 38.00
39.00 ADVERTISING	A	-1,974	PHYSICIANS' PRIVATE OFFICES	192.00 39.00
40.00 ANESTHESIA	A	-509,833	ANESTHESIOLOGY	53.00 40.00
41.00 ANESTHESIA OTHER	A	-147,362	ANESTHESIOLOGY	53.00 41.00
42.00 OTHER REVENUE	B	-6,259	OTHER ADMINISTRATIVE AND GENERAL	5.01 42.00
43.00 CPR	B	-4,274	OTHER ADMINISTRATIVE AND GENERAL	5.01 43.00
44.00 IHA	A	-10,730	OTHER ADMINISTRATIVE AND GENERAL	5.01 44.00
45.00 FMC OTHER REVENUE	B	-105,862	RURAL HEALTH CLINIC	88.00 45.00
45.01		0		0.00 45.01

Provider CCN: 141320
 Period: From 01/01/2011 To 12/31/2011
 Worksheet A-8
 Date/Time Prepared: 5/22/2012 3:48 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #		
			1.00	2.00		3.00
45.02		0			0.00	45.02
45.03 FMC OTHER REVENUE	B	-10,000	PHYSICIANS' PRIVATE OFFICES		192.00	45.03
45.04 AHA	A	-2,777	OTHER ADMINISTRATIVE AND GENERAL		5.01	45.04
45.05		0			0.00	45.05
45.06 HOSPITAL TAX	A	-623,038	OTHER ADMINISTRATIVE AND GENERAL		5.01	45.06
45.07 RADIOLOGY	A	-596,028	RADIOLOGY-DIAGNOSTIC		54.00	45.07
45.08 RADIOLOGY OTHER	A	-154,954	RADIOLOGY-DIAGNOSTIC		54.00	45.08
45.09 WOUND CARE	A	-10,405	OP CLINIC		90.01	45.09
45.10 WOUND CARE OTHER	A	-3,097	OP CLINIC		90.01	45.10
45.11 NON-REIMB DEPR	A	-65,522	NEW CAP REL COSTS-BLDG & FIXT		1.00	45.11
45.12 MCHC DUES	A	-125	OTHER ADMINISTRATIVE AND GENERAL		5.01	45.12
45.13 ADVERTISING	A	-3,404	SENIOR CARE		90.02	45.13
45.14 RADIOLOGY REVENUE	B	-41	RADIOLOGY-DIAGNOSTIC		54.00	45.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,123,188				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8

Date/Time Prepared:
5/22/2012 3:48 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	9	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 - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	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	PHYSICIAN RECRUITING	0	33.00
34.00	ADVERTISING	0	34.00
35.00		0	35.00
36.00	ADVERTISING	0	36.00
37.00	ADVERTISING	0	37.00
38.00	ADVERTISING	0	38.00
39.00	ADVERTISING	0	39.00
40.00	ANESTHESIA	0	40.00
41.00	ANESTHESIA OTHER	0	41.00
42.00	OTHER REVENUE	0	42.00
43.00	CPR	0	43.00
44.00	IHA	0	44.00
45.00	FMC OTHER REVENUE	0	45.00
45.01		0	45.01
45.02		0	45.02
45.03	FMC OTHER REVENUE	0	45.03
45.04	AHA	0	45.04
45.05		0	45.05
45.06	HOSPITAL TAX	0	45.06
45.07	RADIOLOGY	0	45.07
45.08	RADIOLOGY OTHER	0	45.08
45.09	WOUND CARE	0	45.09
45.10	WOUND CARE OTHER	0	45.10
45.11	NON-REIMB DEPR	9	45.11
45.12	MCHC DUES	0	45.12
45.13	ADVERTISING	0	45.13
45.14	RADIOLOGY REVENUE	0	45.14

Provider CCN: 141320

Period:
 From 01/01/2011
 To 12/31/2011

Worksheet A-8

Date/Time Prepared:
 5/22/2012 3:48 pm

Cost Center Description		Wkst. A-7 Ref.	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	5.00	50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-1

Date/Time Prepared:
5/22/2012 3:48 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	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	1.00
2.00	0.00			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	A		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:	OTHER		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: 141320

Period: From 01/01/2011 To 12/31/2011

Worksheet A-8-1

Date/Time Prepared: 5/22/2012 3:48 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	71,249	70,851	398	0	1.00
2.00	0	0	0	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.				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:

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		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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-2

Date/Time Prepared:
5/22/2012 3:48 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	35,673	35,673	1.00
2.00	30.00	ADULTS & PEDIATRICS	85,386	85,386	2.00
3.00	0.00		0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	38,857	38,857	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	96,537	96,537	5.00
6.00	90.00	CLINIC	25,229	16,229	6.00
7.00	90.02	SENIOR CARE	21,500	0	7.00
8.00	91.00	EMERGENCY	1,506,385	1,176,339	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,809,567	1,449,021	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-2

Date/Time Prepared:
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	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	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	9,000	0	0	0	0	6.00
7.00	21,500	0	0	0	0	7.00
8.00	330,046	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	360,546					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-2

Date/Time Prepared:
5/22/2012 3:48 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 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: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-2
Date/Time Prepared:
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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	35,673	1.00
2.00	0	85,386	2.00
3.00	0	0	3.00
4.00	0	38,857	4.00
5.00	0	96,537	5.00
6.00	0	16,229	6.00
7.00	0	0	7.00
8.00	0	1,176,339	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	1,449,021	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,100,686	1,100,686			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	866,097		866,097		2.00
4.00	EMPLOYEE BENEFITS	3,973,963	9,029	7,104	3,990,096	4.00
5.01	OTHER ADMINISTRATIVE AND GENERAL	2,877,497	227,062	178,668	305,798	3,589,025
5.02	ADMITTING	651,183	27,861	21,923	152,262	853,229
7.00	OPERATION OF PLANT	900,775	106,651	83,920	105,081	1,196,427
8.00	LAUNDRY & LINEN SERVICE	112,728	8,785	6,913	0	128,426
9.00	HOUSEKEEPING	236,333	6,163	4,850	58,564	305,910
10.00	DIETARY	245,695	26,347	20,732	49,330	342,104
11.00	CAFETERIA	203,033	12,633	9,941	57,901	283,508
13.00	NURSING ADMINISTRATION	470,610	3,983	3,134	136,066	613,793
15.00	PHARMACY	225,264	7,857	6,183	63,184	302,488
16.00	MEDICAL RECORDS & LIBRARY	354,894	20,184	15,882	90,011	480,971
17.00	SOCIAL SERVICE	45,067	1,424	1,120	0	47,611
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,237,235	126,258	99,349	355,896	1,818,738
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	638,827	72,545	57,084	156,920	925,376
53.00	ANESTHESIOLOGY	20,020	1,072	844	0	21,936
54.00	RADIOLOGY-DIAGNOSTIC	1,319,780	63,976	50,341	216,744	1,650,841
60.00	LABORATORY	1,301,267	27,672	21,774	190,338	1,541,051
65.00	RESPIRATORY THERAPY	165,595	3,433	2,701	47,316	219,045
66.00	PHYSICAL THERAPY	723,044	39,728	31,261	202,421	996,454
69.00	ELECTROCARDIOLOGY	48,046	4,785	3,765	12,831	69,427
70.00	ELECTROENCEPHALOGRAPHY	314	0	0	0	314
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	302,892	0	0	0	302,892
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	776,612	0	0	0	776,612
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	3,735,749	151,831	119,471	976,877	4,983,928
88.01	RURAL HEALTH CLINIC II	252,680	13,516	10,635	60,993	337,824
88.02	RURAL HEALTH CLINIC III	132,468	6,965	5,481	32,548	177,462
90.00	CLINIC	90,329	5,551	4,368	22,524	122,772
90.01	OP CLINIC	328,934	30,681	24,142	87,180	470,937
90.02	SENIOR CARE	361,622	14,417	11,344	2,383	389,766
91.00	EMERGENCY	1,496,691	47,739	37,564	337,076	1,919,070
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,195,930	1,068,148	840,494	3,720,244	24,867,937
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	1,074,107	32,538	25,603	269,852	1,402,100
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	26,270,037	1,100,686	866,097	3,990,096	26,270,037

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.01	ADMITTING 5.02	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	OTHER ADMINISTRATIVE AND GENERAL	3,589,025					5.01
5.02	ADMITTING	135,014	988,243				5.02
7.00	OPERATION OF PLANT	189,321	0	1,385,748			7.00
8.00	LAUNDRY & LINEN SERVICE	20,322	0	16,675	165,423		8.00
9.00	HOUSEKEEPING	48,407	0	11,698	0	366,015	9.00
10.00	DIETARY	54,134	0	50,009	0	13,485	10.00
11.00	CAFETERIA	44,862	0	23,978	0	6,466	11.00
13.00	NURSING ADMINISTRATION	97,126	0	7,559	0	2,038	13.00
15.00	PHARMACY	47,865	0	14,914	0	4,021	15.00
16.00	MEDICAL RECORDS & LIBRARY	76,108	0	38,311	0	10,330	16.00
17.00	SOCIAL SERVICE	7,534	0	2,702	0	729	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	287,795	106,059	239,646	165,423	64,620	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	146,431	53,963	137,696	0	37,130	50.00
53.00	ANESTHESIOLOGY	3,471	0	2,035	0	549	53.00
54.00	RADIOLOGY-DIAGNOSTIC	261,227	96,269	121,431	0	32,744	54.00
60.00	LABORATORY	243,854	89,867	52,523	0	14,163	60.00
65.00	RESPIRATORY THERAPY	34,661	12,773	6,516	0	1,757	65.00
66.00	PHYSICAL THERAPY	157,678	58,107	75,407	0	20,333	66.00
69.00	ELECTROCARDIOLOGY	10,986	4,049	9,082	0	2,449	69.00
70.00	ELECTROENCEPHALOGRAPHY	50	18	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,929	17,664	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	122,890	45,290	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	788,659	310,525	288,186	0	77,709	88.00
88.01	RURAL HEALTH CLINIC II	53,457	15,995	25,654	0	6,918	88.01
88.02	RURAL HEALTH CLINIC III	28,081	8,367	13,221	0	3,565	88.02
90.00	CLINIC	19,427	7,159	10,535	0	2,841	90.00
90.01	OP CLINIC	74,521	27,463	58,235	0	15,703	90.01
90.02	SENIOR CARE	61,676	22,765	27,365	0	7,379	90.02
91.00	EMERGENCY	303,672	111,910	90,611	0	24,433	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,367,158	988,243	1,323,989	165,423	349,362	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	221,867	0	61,759	0	16,653	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,589,025	988,243	1,385,748	165,423	366,015	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

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Part I
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Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
	10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02 ADMITTING						5.02
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	459,732					10.00
11.00 CAFETERIA	0	358,814				11.00
13.00 NURSING ADMINISTRATION	0	14,971	735,487			13.00
15.00 PHARMACY	0	6,952	0	376,240		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	9,904	0	0	615,624	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	459,732	39,158	277,215	40	26,339	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	17,265	126,193	74	56,679	50.00
53.00 ANESTHESIOLOGY	0	0	0	12	7,352	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	23,848	0	2,230	187,592	54.00
60.00 LABORATORY	0	20,942	0	0	125,658	60.00
65.00 RESPIRATORY THERAPY	0	5,206	0	893	3,367	65.00
66.00 PHYSICAL THERAPY	0	22,272	0	189	68,332	66.00
69.00 ELECTROCARDIOLOGY	0	1,412	0	0	11,776	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	2,440	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	21,211	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	333,059	39,695	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	107,482	0	35,026	0	88.00
88.01 RURAL HEALTH CLINIC II	0	6,711	0	1,316	0	88.01
88.02 RURAL HEALTH CLINIC III	0	3,581	0	489	0	88.02
90.00 CLINIC	0	2,478	0	42	1,305	90.00
90.01 OP CLINIC	0	9,592	65,174	2,018	5,244	90.01
90.02 SENIOR CARE	0	262	1,917	0	10,263	90.02
91.00 EMERGENCY	0	37,087	264,988	144	48,371	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	459,732	329,123	735,487	375,532	615,624	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	29,691	0	708	0	192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	459,732	358,814	735,487	376,240	615,624	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.01 OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02 ADMIN TTING					5.02
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	58,576				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	58,576	3,543,341	0	3,543,341	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	1,500,807	0	1,500,807	50.00
53.00 ANESTHESIOLOGY	0	35,355	0	35,355	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	2,376,182	0	2,376,182	54.00
60.00 LABORATORY	0	2,088,058	0	2,088,058	60.00
65.00 RESPIRATORY THERAPY	0	284,218	0	284,218	65.00
66.00 PHYSICAL THERAPY	0	1,398,772	0	1,398,772	66.00
69.00 ELECTROCARDIOLOGY	0	109,181	0	109,181	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	2,822	0	2,822	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	389,696	0	389,696	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,317,546	0	1,317,546	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	6,591,515	0	6,591,515	88.00
88.01 RURAL HEALTH CLINIC II	0	447,875	0	447,875	88.01
88.02 RURAL HEALTH CLINIC III	0	234,766	0	234,766	88.02
90.00 CLINIC	0	166,559	0	166,559	90.00
90.01 OP CLINIC	0	728,887	0	728,887	90.01
90.02 SENIOR CARE	0	521,393	0	521,393	90.02
91.00 EMERGENCY	0	2,800,286	0	2,800,286	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	58,576	24,537,259	0	24,537,259	118.00
NONREIMBURSABLE COST CENTERS					
192.00 PHYSICIANS' PRIVATE OFFICES	0	1,732,778	0	1,732,778	192.00
200.00 Cross Foot Adjustments		0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	58,576	26,270,037	0	26,270,037	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	9,029	7,104	16,133	4.00
5.01	OTHER ADMINISTRATIVE AND GENERAL	0	227,062	178,668	405,730	5.01
5.02	ADMINISTRATIVE	0	27,861	21,923	49,784	5.02
7.00	OPERATION OF PLANT	0	106,651	83,920	190,571	7.00
8.00	LAUNDRY & LINEN SERVICE	0	8,785	6,913	15,698	8.00
9.00	HOUSEKEEPING	0	6,163	4,850	11,013	9.00
10.00	DIETARY	0	26,347	20,732	47,079	10.00
11.00	CAFETERIA	0	12,633	9,941	22,574	11.00
13.00	NURSING ADMINISTRATION	0	3,983	3,134	7,117	13.00
15.00	PHARMACY	0	7,857	6,183	14,040	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	20,184	15,882	36,066	16.00
17.00	SOCIAL SERVICE	0	1,424	1,120	2,544	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	126,258	99,349	225,607	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	72,545	57,084	129,629	50.00
53.00	ANESTHESIOLOGY	0	1,072	844	1,916	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	63,976	50,341	114,317	54.00
60.00	LABORATORY	0	27,672	21,774	49,446	60.00
65.00	RESPIRATORY THERAPY	0	3,433	2,701	6,134	65.00
66.00	PHYSICAL THERAPY	0	39,728	31,261	70,989	66.00
69.00	ELECTROCARDIOLOGY	0	4,785	3,765	8,550	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	151,831	119,471	271,302	88.00
88.01	RURAL HEALTH CLINIC II	0	13,516	10,635	24,151	88.01
88.02	RURAL HEALTH CLINIC III	0	6,965	5,481	12,446	88.02
90.00	CLINIC	0	5,551	4,368	9,919	90.00
90.01	OP CLINIC	0	30,681	24,142	54,823	90.01
90.02	SENIOR CARE	0	14,417	11,344	25,761	90.02
91.00	EMERGENCY	0	47,739	37,564	85,303	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,068,148	840,494	1,908,642	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	32,538	25,603	58,141	192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,100,686	866,097	1,966,783	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	OTHER	ADMINISTRATIVE	ADMINISTRATIVE	OPERATION OF	LAUNDRY &	HOUSEKEEPING	
	ADMINISTRATIVE	AND GENERAL		PLANT	LINEN SERVICE		
	5.01	5.02	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS							
1.00							1.00
2.00							2.00
4.00							4.00
5.01	OTHER ADMINISTRATIVE AND GENERAL	406,966					5.01
5.02	ADMINISTRATIVE	15,309	65,708				5.02
7.00	OPERATION OF PLANT	21,467	0	212,463			7.00
8.00	LAUNDRY & LINEN SERVICE	2,304	0	2,557	20,559		8.00
9.00	HOUSEKEEPING	5,489	0	1,794	0	18,533	9.00
10.00	DIETARY	6,138	0	7,667	0	683	10.00
11.00	CAFETERIA	5,087	0	3,676	0	327	11.00
13.00	NURSING ADMINISTRATION	11,013	0	1,159	0	103	13.00
15.00	PHARMACY	5,428	0	2,287	0	204	15.00
16.00	MEDICAL RECORDS & LIBRARY	8,630	0	5,874	0	523	16.00
17.00	SOCIAL SERVICE	854	0	414	0	37	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	32,634	7,051	36,743	20,559	3,272	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	16,604	3,588	21,112	0	1,880	50.00
53.00	ANESTHESIOLOGY	394	0	312	0	28	53.00
54.00	RADIOLOGY-DIAGNOSTIC	29,621	6,400	18,618	0	1,658	54.00
60.00	LABORATORY	27,651	5,974	8,053	0	717	60.00
65.00	RESPIRATORY THERAPY	3,930	849	999	0	89	65.00
66.00	PHYSICAL THERAPY	17,879	3,863	11,561	0	1,030	66.00
69.00	ELECTROCARDIOLOGY	1,246	269	1,392	0	124	69.00
70.00	ELECTROENCEPHALOGRAPHY	6	1	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,435	1,174	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	13,935	3,011	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	89,427	20,654	44,183	0	3,934	88.00
88.01	RURAL HEALTH CLINIC II	6,062	1,063	3,933	0	350	88.01
88.02	RURAL HEALTH CLINIC III	3,184	556	2,027	0	181	88.02
90.00	CLINIC	2,203	476	1,615	0	144	90.00
90.01	OP CLINIC	8,450	1,826	8,929	0	795	90.01
90.02	SENIOR CARE	6,994	1,513	4,196	0	374	90.02
91.00	EMERGENCY	34,434	7,440	13,893	0	1,237	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	381,808	65,708	202,994	20,559	17,690	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	25,158	0	9,469	0	843	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	406,966	65,708	212,463	20,559	18,533	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
	10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02 ADMITTING						5.02
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	61,766					10.00
11.00 CAFETERIA	0	31,898				11.00
13.00 NURSING ADMINISTRATION	0	1,331	21,273			13.00
15.00 PHARMACY	0	618	0	22,832		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	880	0	0	52,337	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	61,766	3,481	8,019	2	2,238	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	1,535	3,650	4	4,817	50.00
53.00 ANESTHESIOLOGY	0	0	0	1	625	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	2,120	0	135	15,959	54.00
60.00 LABORATORY	0	1,861	0	0	10,680	60.00
65.00 RESPIRATORY THERAPY	0	463	0	54	286	65.00
66.00 PHYSICAL THERAPY	0	1,980	0	11	5,807	66.00
69.00 ELECTROCARDIOLOGY	0	125	0	0	1,001	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	207	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,803	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	20,212	3,374	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	9,559	0	2,126	0	88.00
88.01 RURAL HEALTH CLINIC II	0	596	0	80	0	88.01
88.02 RURAL HEALTH CLINIC III	0	318	0	30	0	88.02
90.00 CLINIC	0	220	0	3	111	90.00
90.01 OP CLINIC	0	853	1,885	122	446	90.01
90.02 SENIOR CARE	0	23	55	0	872	90.02
91.00 EMERGENCY	0	3,296	7,664	9	4,111	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	61,766	29,259	21,273	22,789	52,337	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	2,639	0	43	0	192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	61,766	31,898	21,273	22,832	52,337	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141320

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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.01 OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02 ADMIN TTING					5.02
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	3,849				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	3,849	406,659	0	406,659	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	183,453	0	183,453	50.00
53.00 ANESTHESIOLOGY	0	3,276	0	3,276	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	189,704	0	189,704	54.00
60.00 LABORATORY	0	105,151	0	105,151	60.00
65.00 RESPIRATORY THERAPY	0	12,995	0	12,995	65.00
66.00 PHYSICAL THERAPY	0	113,938	0	113,938	66.00
69.00 ELECTROCARDIOLOGY	0	12,759	0	12,759	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	214	0	214	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,412	0	8,412	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	40,532	0	40,532	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	445,140	0	445,140	88.00
88.01 RURAL HEALTH CLINIC II	0	36,482	0	36,482	88.01
88.02 RURAL HEALTH CLINIC III	0	18,874	0	18,874	88.02
90.00 CLINIC	0	14,782	0	14,782	90.00
90.01 OP CLINIC	0	78,481	0	78,481	90.01
90.02 SENIOR CARE	0	39,798	0	39,798	90.02
91.00 EMERGENCY	0	158,749	0	158,749	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3,849	1,869,399	0	1,869,399	118.00
NONREIMBURSABLE COST CENTERS					
192.00 PHYSICIANS' PRIVATE OFFICES	0	97,384	0	97,384	192.00
200.00 Cross Foot Adjustments		0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	3,849	1,966,783	0	1,966,783	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141320

Period:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	122,153					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		122,153				2.00
4.00 EMPLOYEE BENEFITS	1,002	1,002	13,218,642			4.00
5.01 OTHER ADMINISTRATIVE AND GENERAL	25,199	25,199	1,013,066	-3,589,025	22,681,012	5.01
5.02 ADMITTING	3,092	3,092	504,423	0	853,229	5.02
7.00 OPERATION OF PLANT	11,836	11,836	348,119	0	1,196,427	7.00
8.00 LAUNDRY & LINEN SERVICE	975	975	0	0	128,426	8.00
9.00 HOUSEKEEPING	684	684	194,013	0	305,910	9.00
10.00 DIETARY	2,924	2,924	163,423	0	342,104	10.00
11.00 CAFETERIA	1,402	1,402	191,818	0	283,508	11.00
13.00 NURSING ADMINISTRATION	442	442	450,769	0	613,793	13.00
15.00 PHARMACY	872	872	209,321	0	302,488	15.00
16.00 MEDICAL RECORDS & LIBRARY	2,240	2,240	298,193	0	480,971	16.00
17.00 SOCIAL SERVICE	158	158	0	0	47,611	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	14,012	14,012	1,179,033	0	1,818,738	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	8,051	8,051	519,854	0	925,376	50.00
53.00 ANESTHESIOLOGY	119	119	0	0	21,936	53.00
54.00 RADIOLOGY-DIAGNOSTIC	7,100	7,100	718,043	0	1,650,841	54.00
60.00 LABORATORY	3,071	3,071	630,564	0	1,541,051	60.00
65.00 RESPIRATORY THERAPY	381	381	156,750	0	219,045	65.00
66.00 PHYSICAL THERAPY	4,409	4,409	670,591	0	996,454	66.00
69.00 ELECTROCARDIOLOGY	531	531	42,508	0	69,427	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	314	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	302,892	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	776,612	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	16,850	16,850	3,236,269	0	4,983,928	88.00
88.01 RURAL HEALTH CLINIC II	1,500	1,500	202,062	0	337,824	88.01
88.02 RURAL HEALTH CLINIC III	773	773	107,828	0	177,462	88.02
90.00 CLINIC	616	616	74,618	0	122,772	90.00
90.01 OP CLINIC	3,405	3,405	288,816	0	470,937	90.01
90.02 SENIOR CARE	1,600	1,600	7,896	0	389,766	90.02
91.00 EMERGENCY	5,298	5,298	1,116,684	0	1,919,070	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	118,542	118,542	12,324,661	-3,589,025	21,278,912	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	3,611	3,611	893,981	0	1,402,100	192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,100,686	866,097	3,990,096		3,589,025	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	9.010716	7.090264	0.301854		0.158239	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			16,133		406,966	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001220		0.017943	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141320

Period:
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Cost Center Description	ADMINISTRATIVE (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
	5.02	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02 ADMINISTRATION	16,946,081					5.02
7.00 OPERATION OF PLANT	0	81,024				7.00
8.00 LAUNDRY & LINEN SERVICE	0	975	100			8.00
9.00 HOUSEKEEPING	0	684	0	79,365		9.00
10.00 DIETARY	0	2,924	0	2,924	100	10.00
11.00 CAFETERIA	0	1,402	0	1,402	0	11.00
13.00 NURSING ADMINISTRATION	0	442	0	442	0	13.00
15.00 PHARMACY	0	872	0	872	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	2,240	0	2,240	0	16.00
17.00 SOCIAL SERVICE	0	158	0	158	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,818,656	14,012	100	14,012	100	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	925,340	8,051	0	8,051	0	50.00
53.00 ANESTHESIOLOGY	0	119	0	119	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,650,791	7,100	0	7,100	0	54.00
60.00 LABORATORY	1,541,008	3,071	0	3,071	0	60.00
65.00 RESPIRATORY THERAPY	219,034	381	0	381	0	65.00
66.00 PHYSICAL THERAPY	996,407	4,409	0	4,409	0	66.00
69.00 ELECTROCARDIOLOGY	69,424	531	0	531	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	314	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	302,892	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	776,612	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	5,324,809	16,850	0	16,850	0	88.00
88.01 RURAL HEALTH CLINIC II	274,273	1,500	0	1,500	0	88.01
88.02 RURAL HEALTH CLINIC III	143,477	773	0	773	0	88.02
90.00 CLINIC	122,767	616	0	616	0	90.00
90.01 OP CLINIC	470,918	3,405	0	3,405	0	90.01
90.02 SENIOR CARE	390,367	1,600	0	1,600	0	90.02
91.00 EMERGENCY	1,918,992	5,298	0	5,298	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,946,081	77,413	100	75,754	100	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	3,611	0	3,611	0	192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	988,243	1,385,748	165,423	366,015	459,732	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.058317	17.102932	1,654.230000	4.611794	4,597.320000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	65,708	212,463	20,559	18,533	61,766	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.003877	2.622223	205.590000	0.233516	617.660000	205.00

COST ALLOCATION - STATISTICAL BASIS

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Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (PAT DAYS)	
	11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02 ADMINITTING						5.02
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	10,803,780					11.00
13.00 NURSING ADMINISTRATION	450,769	3,029,849				13.00
15.00 PHARMACY	209,321	0	849,401			15.00
16.00 MEDICAL RECORDS & LIBRARY	298,193	0	0	47,050,778		16.00
17.00 SOCIAL SERVICE	0	0	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,179,033	1,141,991	91	2,013,034	100	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	519,854	519,854	166	4,331,951	0	50.00
53.00 ANESTHESIOLOGY	0	0	28	561,918	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	718,043	0	5,034	14,336,564	0	54.00
60.00 LABORATORY	630,564	0	0	9,603,951	0	60.00
65.00 RESPIRATORY THERAPY	156,750	0	2,015	257,339	0	65.00
66.00 PHYSICAL THERAPY	670,591	0	427	5,222,553	0	66.00
69.00 ELECTROCARDIOLOGY	42,508	0	0	900,028	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	186,483	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,621,148	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	751,915	3,033,878	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	3,236,269	0	79,075	0	0	88.00
88.01 RURAL HEALTH CLINIC II	202,062	0	2,972	0	0	88.01
88.02 RURAL HEALTH CLINIC III	107,828	0	1,104	0	0	88.02
90.00 CLINIC	74,618	0	95	99,725	0	90.00
90.01 OP CLINIC	288,816	268,487	4,555	400,825	0	90.01
90.02 SENIOR CARE	7,896	7,896	0	784,423	0	90.02
91.00 EMERGENCY	1,116,684	1,091,621	326	3,696,958	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9,909,799	3,029,849	847,803	47,050,778	100	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	893,981	0	1,598	0	0	192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	358,814	735,487	376,240	615,624	58,576	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.033212	0.242747	0.442947	0.013084	585.760000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	31,898	21,273	22,832	52,337	3,849	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.002952	0.007021	0.026880	0.001112	38.490000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet C
Part I
Date/Time Prepared:
5/22/2012 3:48 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		3,543,341	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		1,500,807	0	0	50.00
53.00	ANESTHESIOLOGY		35,355	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		2,376,182	0	0	54.00
60.00	LABORATORY		2,088,058	0	0	60.00
65.00	RESPIRATORY THERAPY	0	284,218	0	0	65.00
66.00	PHYSICAL THERAPY	0	1,398,772	0	0	66.00
69.00	ELECTROCARDIOLOGY		109,181	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY		2,822	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		389,696	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,317,546	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		6,591,515	0	0	88.00
88.01	RURAL HEALTH CLINIC II		447,875	0	0	88.01
88.02	RURAL HEALTH CLINIC III		234,766	0	0	88.02
90.00	CLINIC		166,559	0	0	90.00
90.01	OP CLINIC		728,887	0	0	90.01
90.02	SENIOR CARE		521,393	0	0	90.02
91.00	EMERGENCY		2,800,286	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		323,251	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		24,860,510	0	0	200.00
201.00	Less Observation Beds		323,251			201.00
202.00	Total (see instructions)		24,537,259	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet C
Part I
Date/Time Prepared:
5/22/2012 3:48 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,837,920		1,837,920			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	324,521	4,007,430	4,331,951	0.346451	0.000000	50.00
53.00	ANESTHESIOLOGY	54,888	507,030	561,918	0.062918	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	487,916	13,848,648	14,336,564	0.165743	0.000000	54.00
60.00	LABORATORY	521,685	9,082,266	9,603,951	0.217417	0.000000	60.00
65.00	RESPIRATORY THERAPY	170,098	87,241	257,339	1.104450	0.000000	65.00
66.00	PHYSICAL THERAPY	504,456	4,718,097	5,222,553	0.267833	0.000000	66.00
69.00	ELECTROCARDIOLOGY	30,166	869,862	900,028	0.121308	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	186,483	186,483	0.015133	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	480,860	1,140,288	1,621,148	0.240383	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	801,585	2,232,293	3,033,878	0.434278	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	5,686,201	5,686,201			88.00
88.01	RURAL HEALTH CLINIC II	0	273,938	273,938			88.01
88.02	RURAL HEALTH CLINIC III	0	99,165	99,165			88.02
90.00	CLINIC	0	99,725	99,725	1.670183	0.000000	90.00
90.01	OP CLINIC	2,871	397,954	400,825	1.818467	0.000000	90.01
90.02	SENIOR CARE	0	784,423	784,423	0.664683	0.000000	90.02
91.00	EMERGENCY	83,427	3,613,531	3,696,958	0.757457	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	7,727	167,388	175,115	1.845936	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	5,308,120	47,801,963	53,110,083			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	5,308,120	47,801,963	53,110,083			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet C
Part I
Date/Time Prepared:
5/22/2012 3:48 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	LABORATORY	0.000000			60.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	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
88.02	RURAL HEALTH CLINIC III				88.02
90.00	CLINIC	0.000000			90.00
90.01	OP CLINIC	0.000000			90.01
90.02	SENIOR CARE	0.000000			90.02
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/22/2012 3:48 pm
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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	183,453	4,331,951	0.042349	92,530	3,919	50.00
53.00	ANESTHESIOLOGY	3,276	561,918	0.005830	13,829	81	53.00
54.00	RADIOLOGY-DIAGNOSTIC	189,704	14,336,564	0.013232	199,702	2,642	54.00
60.00	LABORATORY	105,151	9,603,951	0.010949	275,881	3,021	60.00
65.00	RESPIRATORY THERAPY	12,995	257,339	0.050498	65,312	3,298	65.00
66.00	PHYSICAL THERAPY	113,938	5,222,553	0.021817	61,715	1,346	66.00
69.00	ELECTROCARDIOLOGY	12,759	900,028	0.014176	20,068	284	69.00
70.00	ELECTROENCEPHALOGRAPHY	214	186,483	0.001148	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,412	1,621,148	0.005189	147,534	766	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	40,532	3,033,878	0.013360	456,992	6,105	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	445,140	5,686,201	0.078284	0	0	88.00
88.01	RURAL HEALTH CLINIC II	36,482	273,938	0.133176	0	0	88.01
88.02	RURAL HEALTH CLINIC III	18,874	99,165	0.190329	0	0	88.02
90.00	CLINIC	14,782	99,725	0.148228	0	0	90.00
90.01	OP CLINIC	78,481	400,825	0.195799	2,430	476	90.01
90.02	SENIOR CARE	39,798	784,423	0.050735	0	0	90.02
91.00	EMERGENCY	158,749	3,696,958	0.042940	2,635	113	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	175,115	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,462,740	51,272,163		1,338,628	22,051	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet D
Part IV
Date/Time Prepared:
5/22/2012 3:48 pm

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Cost
		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
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
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
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	CLINIC	0	0	0	0	0	90.00
90.01	OP CLINIC	0	0	0	0	0	90.01
90.02	SENIOR CARE	0	0	0	0	0	90.02
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet D
Part IV
Date/Time Prepared:
5/22/2012 3:48 pm

Cost Center Description		Title XVIII			Hospital		
		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	4,331,951	0.000000	0.000000	92,530	50.00
53.00	ANESTHESIOLOGY	0	561,918	0.000000	0.000000	13,829	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	14,336,564	0.000000	0.000000	199,702	54.00
60.00	LABORATORY	0	9,603,951	0.000000	0.000000	275,881	60.00
65.00	RESPIRATORY THERAPY	0	257,339	0.000000	0.000000	65,312	65.00
66.00	PHYSICAL THERAPY	0	5,222,553	0.000000	0.000000	61,715	66.00
69.00	ELECTROCARDIOLOGY	0	900,028	0.000000	0.000000	20,068	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	186,483	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,621,148	0.000000	0.000000	147,534	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,033,878	0.000000	0.000000	456,992	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	5,686,201	0.000000	0.000000	0	88.00
88.01	RURAL HEALTH CLINIC II	0	273,938	0.000000	0.000000	0	88.01
88.02	RURAL HEALTH CLINIC III	0	99,165	0.000000	0.000000	0	88.02
90.00	CLINIC	0	99,725	0.000000	0.000000	0	90.00
90.01	OP CLINIC	0	400,825	0.000000	0.000000	2,430	90.01
90.02	SENIOR CARE	0	784,423	0.000000	0.000000	0	90.02
91.00	EMERGENCY	0	3,696,958	0.000000	0.000000	2,635	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	175,115	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	51,272,163			1,338,628	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet D
Part IV
Date/Time Prepared:
5/22/2012 3:48 pm

Cost Center Description		Title XVIII			Hospital	Cost
		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
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
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
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	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
88.02	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	CLINIC	0	0	0		90.00
90.01	OP CLINIC	0	0	0		90.01
90.02	SENIOR CARE	0	0	0		90.02
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/22/2012 3:48 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost		
			Reimbursed Services Subject To Ded. & Coins. (see instructions)	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	0.346451	0	0	1,419,597	50.00
53.00 ANESTHESIOLOGY	0.062918	0	0	173,991	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.165743	0	0	4,055,766	54.00
60.00 LABORATORY	0.217417	0	0	3,624,232	60.00
65.00 RESPIRATORY THERAPY	1.104450	0	0	30,842	65.00
66.00 PHYSICAL THERAPY	0.267833	0	0	1,490,247	66.00
69.00 ELECTROCARDIOLOGY	0.121308	0	0	354,205	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.015133	0	0	8,546	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240383	0	0	498,600	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.434278	0	0	1,094,565	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
88.02 RURAL HEALTH CLINIC III	0.000000				88.02
90.00 CLINIC	1.670183	0	0	56,006	90.00
90.01 OP CLINIC	1.818467	0	0	247,852	90.01
90.02 SENIOR CARE	0.664683	0	0	743,219	90.02
91.00 EMERGENCY	0.757457	0	0	998,472	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.845936	0	0	67,949	92.00
200.00 Subtotal (see instructions)		0	0	14,864,089	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	14,864,089	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/22/2012 3:48 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	0	491,821		50.00
53.00 ANESTHESIOLOGY	0	0	10,947		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	672,215		54.00
60.00 LABORATORY	0	0	787,970		60.00
65.00 RESPIRATORY THERAPY	0	0	34,063		65.00
66.00 PHYSICAL THERAPY	0	0	399,137		66.00
69.00 ELECTROCARDIOLOGY	0	0	42,968		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	129		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	119,855		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	475,345		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
88.02 RURAL HEALTH CLINIC III	0	0	0		88.02
90.00 CLINIC	0	0	93,540		90.00
90.01 OP CLINIC	0	0	450,711		90.01
90.02 SENIOR CARE	0	0	494,005		90.02
91.00 EMERGENCY	0	0	756,300		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	125,430		92.00
200.00 Subtotal (see instructions)	0	0	4,954,436		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	4,954,436		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141320 Component CCN: 14Z320	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/22/2012 3:48 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	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	0.346451	0	0	0	50.00
53.00 ANESTHESIOLOGY	0.062918	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.165743	0	0	0	54.00
60.00 LABORATORY	0.217417	0	0	0	60.00
65.00 RESPIRATORY THERAPY	1.104450	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.267833	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0.121308	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.015133	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240383	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.434278	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
88.02 RURAL HEALTH CLINIC III	0.000000				88.02
90.00 CLINIC	1.670183	0	0	0	90.00
90.01 OP CLINIC	1.818467	0	0	0	90.01
90.02 SENIOR CARE	0.664683	0	0	0	90.02
91.00 EMERGENCY	0.757457	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.845936	0	0	0	92.00
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: 141320 Component CCN: 14Z320	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/22/2012 3:48 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
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00 LABORATORY	0	0	0		60.00
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
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	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
88.02 RURAL HEALTH CLINIC III	0	0	0		88.02
90.00 CLINIC	0	0	0		90.00
90.01 OP CLINIC	0	0	0		90.01
90.02 SENIOR CARE	0	0	0		90.02
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet D
Part V
Date/Time Prepared:
5/22/2012 3:48 pm

		Title XIX		Hospital		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	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	0.000000	0	778,009	0	50.00
53.00	ANESTHESIOLOGY	0.000000	0	106,781	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	3,305,272	0	54.00
60.00	LABORATORY	0.000000	0	1,475,602	0	60.00
65.00	RESPIRATORY THERAPY	0.000000	0	16,454	0	65.00
66.00	PHYSICAL THERAPY	0.000000	0	746,511	0	66.00
69.00	ELECTROCARDIOLOGY	0.000000	0	192,511	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	14,559	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	198,725	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	0	358,596	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
88.02	RURAL HEALTH CLINIC III	0.000000				88.02
90.00	CLINIC	0.000000	0	3,884	0	90.00
90.01	OP CLINIC	0.000000	0	7,145	0	90.01
90.02	SENIOR CARE	0.000000	0	660	0	90.02
91.00	EMERGENCY	0.000000	0	1,123,735	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	24,433	0	92.00
200.00	Subtotal (see instructions)		0	8,352,877	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	8,352,877	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/22/2012 3:48 pm
Title XIX		Hospital	

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
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00 LABORATORY	0	0	0		60.00
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
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	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
88.02 RURAL HEALTH CLINIC III	0	0	0		88.02
90.00 CLINIC	0	0	0		90.00
90.01 OP CLINIC	0	0	0		90.01
90.02 SENIOR CARE	0	0	0		90.02
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
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: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/22/2012 3:48 pm
Cost Center Description		Cost		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,552	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,495	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,495	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		633	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)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		3,424	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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		841	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)		633	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)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,543,341	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)		402,354	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)		0	25.00
26.00	Total swing-bed cost (see instructions)		1,336,681	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,206,660	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,268,514	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,268,514	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.739563	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)		848.50	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)		2,206,660	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)		1,476.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,241,341	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)		1,241,341	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/22/2012 3:48 pm
Title XVIII			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					457,446 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,698,787 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)					934,327 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					934,327 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)					219 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,476.03 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					323,251 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141320		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/22/2012 3:48 pm	
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: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/22/2012 3:48 pm	
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		718,830		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.346451	92,530	32,057	50.00
53.00	ANESTHESIOLOGY	0.062918	13,829	870	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.165743	199,702	33,099	54.00
60.00	LABORATORY	0.217417	275,881	59,981	60.00
65.00	RESPIRATORY THERAPY	1.104450	65,312	72,134	65.00
66.00	PHYSICAL THERAPY	0.267833	61,715	16,529	66.00
69.00	ELECTROCARDIOLOGY	0.121308	20,068	2,434	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.015133	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240383	147,534	35,465	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.434278	456,992	198,462	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
88.02	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	CLINIC	1.670183	0	0	90.00
90.01	OP CLINIC	1.818467	2,430	4,419	90.01
90.02	SENIOR CARE	0.664683	0	0	90.02
91.00	EMERGENCY	0.757457	2,635	1,996	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.845936	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,338,628	457,446	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,338,628		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 14Z320		Date/Time Prepared: 5/22/2012 3:48 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		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.346451	0	0	50.00
53.00	ANESTHESIOLOGY	0.062918	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.165743	12,033	1,994	54.00
60.00	LABORATORY	0.217417	23,531	5,116	60.00
65.00	RESPIRATORY THERAPY	1.104450	14,727	16,265	65.00
66.00	PHYSICAL THERAPY	0.267833	362,929	97,204	66.00
69.00	ELECTROCARDIOLOGY	0.121308	879	107	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.015133	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.240383	22,252	5,349	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.434278	118,292	51,372	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
88.02	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	CLINIC	1.670183	0	0	90.00
90.01	OP CLINIC	1.818467	230	418	90.01
90.02	SENIOR CARE	0.664683	0	0	90.02
91.00	EMERGENCY	0.757457	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.845936	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		554,873	177,825	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		554,873		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/22/2012 3:48 pm
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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		190,520		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000	55,831	0	50.00
53.00	ANESTHESIOLOGY	0.000000	10,057	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	76,370	0	54.00
60.00	LABORATORY	0.000000	81,014	0	60.00
65.00	RESPIRATORY THERAPY	0.000000	11,071	0	65.00
66.00	PHYSICAL THERAPY	0.000000	4,479	0	66.00
69.00	ELECTROCARDIOLOGY	0.000000	2,109	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	38,128	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	86,025	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0.000000	0	0	88.02
90.00	CLINIC	0.000000	0	0	90.00
90.01	OP CLINIC	0.000000	0	0	90.01
90.02	SENIOR CARE	0.000000	0	0	90.02
91.00	EMERGENCY	0.000000	34,636	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,621	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		402,341	0	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)		402,341		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/22/2012 3:48 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,954,436 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)			4,954,436 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 charge basis 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)			5,003,980 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)			47,620 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,220,798 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)			2,735,562 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)			2,735,562 30.00
31.00	Primary payer payments			3,262 31.00
32.00	Subtotal (line 30 minus line 31)			2,732,300 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)			705,233 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			705,233 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,437,533 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)			3,437,533 40.00
41.00	Interim payments			3,353,245 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)			84,288 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet E-1
Part I
Date/Time Prepared:
5/22/2012 3:48 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		1,444,157		3,145,038	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		60,644		617,933	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	08/12/2011	6,006	08/12/2011	148,263	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	12/02/2011	59,757	12/02/2011	557,989	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)		-53,751		-409,726	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)		1,451,050		3,353,245	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		104,097		84,288	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,555,147		3,437,533	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: 141320

Period: From 01/01/2011

Worksheet E-1

Component CCN: 14Z320

To 12/31/2011

Part I
Date/Time Prepared:
5/22/2012 3:48 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,109,118		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	08/12/2011	11,046		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	12/02/2011	26,936		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)		-15,890		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,093,228		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		18,017		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,111,245		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: 141320

Period:

Worksheet E-2

Component CCN: 14Z320

From 01/01/2011
To 12/31/2011

Date/Time Prepared:
5/22/2012 3:48 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)		943,670	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)		179,603	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		633	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,123,273	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,123,273	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,123,273	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		12,028	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,111,245	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)		1,111,245	0	19.00
20.00	Interim payments		1,093,228	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)		18,017	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/22/2012 3:48 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			1,698,787 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			1,698,787 4.00
5.00	Primary payer payments			1,628 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			1,714,147 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,714,147 19.00
20.00	Deductibles (exclude professional component)			238,852 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,475,295 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,475,295 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			79,852 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			79,852 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			1,555,147 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)			1,555,147 30.00
31.00	Interim payments			1,451,050 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)			104,097 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			220,434 34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet G

Date/Time Prepared:
5/22/2012 3:48 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,434,628	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,950,620	0	0	0	4.00
5.00	Other receivable	1,155,707	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,310,231	0	0	0	6.00
7.00	Inventory	462,569	0	0	0	7.00
8.00	Prepaid expenses	535,405	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,363,780	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,592,478	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	35,052,360	0	0	0	15.00
16.00	Accumulated depreciation	-18,667,914	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,384,446	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	155,422	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	12,092,827	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,248,249	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,225,173	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,520,711	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,399,016	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	281,128	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	783,178	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,984,033	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,554,202	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)	4,554,202	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,538,235	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	33,686,938				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)	33,686,938	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,225,173	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet G-1

Date/Time Prepared:
5/22/2012 3:48 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		30,263,679	
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,423,255			2.00
3.00	Total (sum of line 1 and line 2)		33,686,934		0	3.00
4.00	Additions (credit adjustments) (specify)	4		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		4		0	10.00
11.00	Subtotal (line 3 plus line 10)		33,686,938		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)		33,686,938		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet G-1

Date/Time Prepared:
5/22/2012 3:48 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00			0		0	10.00
11.00			0		0	11.00
12.00	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			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet G-2 Parts

Date/Time Prepared:
5/22/2012 3:48 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,268,514		1,268,514	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	744,520		744,520	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,013,034		2,013,034	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,013,034		2,013,034	17.00
18.00	Ancillary services	3,459,602	40,293,169	43,752,771	18.00
19.00	Outpatient services	2,871	1,282,101	1,284,972	19.00
20.00	RURAL HEALTH CLINIC	0	5,686,201	5,686,201	20.00
20.01	RURAL HEALTH CLINIC II	0	273,938	273,938	20.01
20.02	RURAL HEALTH CLINIC III	0	99,165	99,165	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	812,470	9,583,290	10,395,760	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,287,977	57,217,864	63,505,841	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,393,225		29.00
30.00	BAD DEBTS	4,056,613			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)		4,056,613		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		34,449,838		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141320

Period:
From 01/01/2011
To 12/31/2011

Worksheet G-3

Date/Time Prepared:
5/22/2012 3:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	63,505,841	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,060,080	2.00
3.00	Net patient revenues (line 1 minus line 2)	35,445,761	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,449,838	4.00
5.00	Net income from service to patients (line 3 minus line 4)	995,923	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	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	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,619,964	24.00
24.01	NON-OPERATING INCOME	807,368	24.01
25.00	Total other income (sum of lines 6-24)	2,427,332	25.00
26.00	Total (line 5 plus line 25)	3,423,255	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,423,255	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2011 To 12/31/2011	Worksheet M-1 Date/Time Prepared: 5/22/2012 3:48 pm
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		Title XVIII		Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	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	1,640,883	0	1,640,883	0	1,640,883
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	186,001	0	186,001	0	186,001
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	650,305	0	650,305	0	650,305
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	25	0	25	0	25
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1-9)	2,477,214	0	2,477,214	0	2,477,214
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0
15.00	Medical Supplies	0	3,876	3,876	0	3,876
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	141,193	141,193	0	141,193
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15-20)	0	145,069	145,069	0	145,069
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,477,214	145,069	2,622,283	0	2,622,283
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	79,690	79,690	0	79,690
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
26.00	All other nonreimbursable costs	0	189,350	189,350	0	189,350
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	269,040	269,040	0	269,040
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	759,055	248,800	1,007,855	-26,891	980,964
31.00	Total Facility Overhead (sum of lines 29 and 30)	759,055	248,800	1,007,855	-26,891	980,964
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,236,269	662,909	3,899,178	-26,891	3,872,287

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

Provider CCN: 141320

Period: From 01/01/2011

Worksheet M-1

Component CCN: 143987

To 12/31/2011

Date/Time Prepared: 5/22/2012 3:48 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	1,640,883	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	186,001	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	650,305	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	25	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	2,477,214	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	3,876	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	141,193	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	145,069	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,622,283	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	79,690	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	189,350	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	269,040	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-136,538	844,426	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-136,538	844,426	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-136,538	3,735,749	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2011 To 12/31/2011	Worksheet M-1 Date/Time Prepared: 5/22/2012 3:48 pm
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		Title XVIII		Rural Health Clinic (RHC) II	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	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	12,000	0	12,000	0	12,000
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	97,348	0	97,348	0	97,348
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	44,564	0	44,564	0	44,564
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	3	0	3	0	3
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1-9)	153,915	0	153,915	0	153,915
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0
15.00	Medical Supplies	0	108	108	0	108
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	663	663	0	663
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15-20)	0	771	771	0	771
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	153,915	771	154,686	0	154,686
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	2,244	2,244	0	2,244
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
26.00	All other nonreimbursable costs	0	20,518	20,518	0	20,518
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	22,762	22,762	0	22,762
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	48,147	59,610	107,757	-29,046	78,711
31.00	Total Facility Overhead (sum of lines 29 and 30)	48,147	59,610	107,757	-29,046	78,711
32.00	Total facility costs (sum of lines 22, 28 and 31)	202,062	83,143	285,205	-29,046	256,159

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2011 To 12/31/2011	Worksheet M-1 Date/Time Prepared: 5/22/2012 3:48 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	12,000
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	97,348
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	44,564
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	3
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	153,915
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	0
15.00	Medical Supplies	0	108
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	663
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	771
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	154,686
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	2,244
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	20,518
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	22,762
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	-3,479	75,232
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,479	75,232
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,479	252,680

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143431	Period: From 01/01/2011 To 12/31/2011	Worksheet M-1 Date/Time Prepared: 5/22/2012 3:48 pm
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		Title XVIII		Rural Health Clinic (RHC) III	Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	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	10,800	0	10,800	0	10,800	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	59,677	0	59,677	0	59,677	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	21,442	0	21,442	0	21,442	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	1	0	1	0	1	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	91,920	0	91,920	0	91,920	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	52	52	0	52	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	730	730	0	730	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	782	782	0	782	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	91,920	782	92,702	0	92,702	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	1,076	1,076	0	1,076	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	6,941	6,941	0	6,941	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	8,017	8,017	0	8,017	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	15,908	33,722	49,630	-16,672	32,958	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	15,908	33,722	49,630	-16,672	32,958	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	107,828	42,521	150,349	-16,672	133,677	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143431	Period: From 01/01/2011 To 12/31/2011	Worksheet M-1 Date/Time Prepared: 5/22/2012 3:48 pm
	Title XVIII	Rural Health Clinic (RHC) III	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	10,800
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	59,677
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	21,442
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	1
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	91,920
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	0
15.00	Medical Supplies	0	52
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	730
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	782
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	92,702
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	1,076
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	6,941
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	8,017
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	-1,209	31,749
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,209	31,749
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,209	132,468

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet M-2			
		Component CCN: 143987		Date/Time Prepared: 5/22/2012 3:48 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		
VI SITS AND PRODUCTI VI TY							
Posi ti ons							
1.00	Physi ci an	3.74	38,000	4,200	15,708	1.00	
2.00	Physi ci an Assistant	0.00	0	2,100	0	2.00	
3.00	Nurse Practitioner	1.00	5,087	2,100	2,100	3.00	
4.00	Subtotal (sum of lines 1-3)	4.74	43,087		17,808	43,087	4.00
5.00	Visi ting 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 Nutri tion Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Sel f Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	4.74	43,087			43,087	8.00
9.00	Physi ci an Servi ces Under Agreements		0			0	9.00
					1.00		
DETERMINATION OF ALLOWABLE COST APPLI CABLE TO RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				2,622,283	10.00	
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				269,040	11.00	
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				2,891,323	12.00	
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				0.906949	13.00	
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				844,426	14.00	
15.00	Parent provider overhead allocated to facility (see instructions)				2,855,766	15.00	
16.00	Total overhead (sum of lines 14 and 15)				3,700,192	16.00	
17.00	Allowable GME overhead (see instructions)				0	17.00	
18.00	Subtract line 17 from line 16				3,700,192	18.00	
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				3,355,885	19.00	
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				5,978,168	20.00	

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet M-2		
		Component CCN: 143989		Date/Time Prepared: 5/22/2012 3:48 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	0.01	1	4,200	42	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.72	2,169	2,100	1,512	3.00
4.00	Subtotal (sum of lines 1-3)	0.73	2,170		1,554	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.73	2,170			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)				154,686	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				22,762	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				177,448	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				0.871726	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				75,232	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				195,195	15.00
16.00	Total overhead (sum of lines 14 and 15)				270,427	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				270,427	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				235,738	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				390,424	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet M-2		
		Component CCN: 143431		Date/Time Prepared: 5/22/2012 3:48 pm		
		Title XVIII	Rural Health Clinic (RHC) III	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.01	9	4,200	42	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.51	796	2,100	1,071	3.00
4.00	Subtotal (sum of lines 1-3)	0.52	805		1,113	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.52	805		1,113	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)				92,702	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				8,017	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				100,719	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				0.920402	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				31,749	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				102,298	15.00
16.00	Total overhead (sum of lines 14 and 15)				134,047	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				134,047	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				123,377	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				216,079	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet M-3
		Component CCN: 143987		Date/Time Prepared: 5/22/2012 3:48 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)		5,978,168	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		42,425	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		5,935,743	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		43,087	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)		43,087	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		137.76	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	137.76	137.76	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	9,590	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,321,118	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	1,321,118	16.00
16.01	Total program charges (see instructions)(from contractor's records)		896,738	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,463	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,629	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		948,114	16.04
16.05	Total program cost (see instructions)		951,743	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		132,346	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)		951,743	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		23,335	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		975,078	22.00
23.00	Reimbursable bad debts (see instructions)		63,251	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)		1,038,329	26.00
27.00	Interim payments		841,207	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)		197,122	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet M-3
		Component CCN: 143989		Date/Time Prepared: 5/22/2012 3:48 pm
		Title XVII I	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)		390,424	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		3,043	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		387,381	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,170	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,170	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		178.52	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	178.52	178.52	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	376	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	67,124	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	67,124	16.00
16.01	Total program charges (see instructions)(from contractor's records)		33,495	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		97	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		194	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		47,358	16.04
16.05	Total program cost (see instructions)		47,552	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,733	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)		47,552	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,484	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		49,036	22.00
23.00	Reimbursable bad debts (see instructions)		1,629	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)		50,665	26.00
27.00	Interim payments		48,594	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)		2,071	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet M-3
		Component CCN: 143431		Date/Time Prepared: 5/22/2012 3:48 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		216,079	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		1,954	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		214,125	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,113	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,113	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		192.39	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	192.39	192.39	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	106	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	20,393	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	20,393	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		14,856	16.04
16.05	Total program cost (see instructions)		14,856	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,823	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)		14,856	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,220	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		16,076	22.00
23.00	Reimbursable bad debts (see instructions)		612	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)		16,688	26.00
27.00	Interim payments		13,297	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)		3,391	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2011 To 12/31/2011	Worksheet M-4 Date/Time Prepared: 5/22/2012 3:48 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	2,477,214	2,477,214	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,976	10,620	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,976	10,620	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	2,622,283	2,622,283	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	3,700,192	3,700,192	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002660	0.004050	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	9,843	14,986	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	16,819	25,606	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	109	708	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	154.30	36.17	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	57	402	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	8,795	14,540	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)		42,425	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)		23,335	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet M-4
		Component CCN: 143989		Date/Time Prepared: 5/22/2012 3:48 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	153,915	153,915	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	192	915	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	192	915	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	154,686	154,686	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	270,427	270,427	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001241	0.005915	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	336	1,600	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	528	2,515	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	3	61	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	176.00	41.23	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	36	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	1,484	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)		3,043	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)		1,484	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141320	Period: From 01/01/2011 To 12/31/2011	Worksheet M-4
		Component CCN: 143431		Date/Time Prepared: 5/22/2012 3:48 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	91,920	91,920	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	64	735	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	64	735	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	92,702	92,702	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	134,047	134,047	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000690	0.007929	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	92	1,063	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	156	1,798	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1	49	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	156.00	36.69	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	29	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	156	1,064	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		1,954	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)		1,220	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2011 To 12/31/2011	Worksheet M-5 Date/Time Prepared: 5/22/2012 3:48 pm	
		Title VIII	Rural Health Clinic (RHC) I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider			814,717	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			08/12/2011	26,490	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			26,490	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			841,207	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			197,122	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			1,038,329	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: 141320 Component CCN: 143989	Period: From 01/01/2011 To 12/31/2011	Worksheet M-5 Date/Time Prepared: 5/22/2012 3:48 pm
	Title VIII	Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		44,634	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		08/12/2011	3,960	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,960	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		48,594	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		2,071	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		50,665	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: 141320 Component CCN: 143431	Period: From 01/01/2011 To 12/31/2011	Worksheet M-5 Date/Time Prepared: 5/22/2012 3:48 pm	
		Title XVIII	Rural Health Clinic (RHC) III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider			13,297	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			13,297	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			3,391	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			16,688	7.00
			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00