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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 1/16/2012 10:03 am

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 1/16/2012 Time: 10:03 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANKLIN HOSPITAL for the cost reporting period beginning 07/31/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-419,597	-663,566	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	-96,134	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		60,431		0	10.00
10.01	RURAL HEALTH CLINIC II II	0		36,364		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-515,731	-566,771	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/16/2012 9:44 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 BAILEY LANE	PO Box:			1.00
2.00	City: BENTON	State: IL	Zip Code: 62812	County: FRANKLIN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	FRANKLIN HOSPITAL	141321	14999	1	08/01/2002	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FRANKLIN HOSPITAL SWING BED	14Z321	14999		08/01/2002	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FRANKLIN RHC	143469	14999		07/06/2005	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1	WEST FRANKFORT RHC II	148510	14999		04/23/2010	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/31/2010	06/30/2011	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? 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	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible 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 then enter the in-state Mediciad paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid 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	25.00

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

		Beginning: 1.00	Ending: 2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/16/2012 9:44 am

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

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	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	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

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

	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	1.00	2.00	3.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 1/16/2012 9:44 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/16/2012 9:44 am

		V	XIX	
		1.00	2.00	
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	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	N	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	0	0	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/16/2012 9:44 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/16/2012 9:44 am

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

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

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

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	09/30/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/16/2012 9:44 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/16/2012 9:44 am

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/30/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
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: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet S-3 Part I Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	29,496.00		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	29,496.00		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	29,496.00		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
26.25	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: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,086	41	1,229		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	229	0	229		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,315	41	1,458		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	1,315	41	1,458		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	418	0	13,003		26.00
26.01	RURAL HEALTH CLINIC II	0	418	0	2,586		26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	162		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: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/16/2012 9:44 am

	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	290	1.00
2.00	HMO					0	2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	131.02	0.00	0	290	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	21.07	0.00			26.00
26.01	RURAL HEALTH CLINIC II	0.00	4.99	0.00			26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	157.08	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: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/16/2012 9:44 am

	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)	17	345		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)	17	345		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
26.25	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: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet S-3 Part IV Date/Time Prepared: 1/16/2012 9:44 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	79,055	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	0	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)	724,053	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	14,183	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	107,620	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	397,221	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	15,759	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,337,891	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: 141321 Component CCN: 143469

Period: From 07/31/2010 To 06/30/2011

Worksheet S-8

Date/Time Prepared: 1/16/2012 9:44 am

		Rural Health Clinic (RHC) I	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	201 BAILEY LANE		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	BENTON	IL	62812 2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic	09:00	22:00	09:00	22:00	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	FRANKLIN RHC	143469	14.00

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141321 Component CCN: 143469	Period: From 07/31/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/16/2012 9:44 am
		Rural Health Clinic (RHC) I	Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		FRANKLIN				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	22:00	09:00	22:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141321 Component CCN: 143469	Period: From 07/31/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/16/2012 9:44 am
		Rural Health Clinic (RHC) I	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	22:00	09:00	22:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141321 Component CCN: 143469	Period: From 07/31/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/16/2012 9:44 am
		Rural Health Clinic (RHC) I	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	09:00	22:00		11.00

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

Provider CCN: 141321 Component CCN: 148510

Period: From 07/31/2010 To 06/30/2011

Worksheet S-8

Date/Time Prepared: 1/16/2012 9:44 am

		Rural Health Clinic (RHC) II	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	201 BAILEY LANE		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	BENTON	IL	62812 2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic	09:00	22:00	09:00	22:00	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	WEST FRANKFORT CLINIC	148510	14.00

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141321 Component CCN: 148510	Period: From 07/31/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/16/2012 9:44 am
		Rural Health Clinic (RHC) II	Cost

			County					
			4.00					
2.00	City, State, Zip Code, County		FRANKLIN					2.00
		Tuesday		Wednesday				
		from	to	from	to			
		5.00	6.00	7.00	8.00			
	Facility hours of operations (1)							
11.00	Clinic	09:00	22:00	09:00	22:00			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141321 Component CCN: 148510	Period: From 07/31/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/16/2012 9:44 am
		Rural Health Clinic (RHC) II	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	22:00	09:00	22:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141321 Component CCN: 148510	Period: From 07/31/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/16/2012 9:44 am
		Rural Health Clinic (RHC) II	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	09:00	22:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/16/2012 9:44 am

		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)	0.526347	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,079,243	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?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	878,805	5.00
6.00	Medicaid charges	5,998,133	6.00
7.00	Medicaid cost (line 1 times line 6)	3,157,099	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)	1,199,051	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)	1,199,051	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	120,227	6,665	126,892	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	63,281	3,508	66,789	21.00
22.00	Partial payment by patients approved for charity care	11,859	15	11,874	22.00
23.00	Cost of charity care (line 21 minus line 22)	51,422	3,493	54,915	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)	2,270,568	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	392,493	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,878,075	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	988,519	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,043,434	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,242,485	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/16/2012 9:44 am

	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	CAP REL COSTS-BLDG & FIXT		262,655	262,655	0	262,655	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		276,618	276,618	20,231	296,849	2.00
4.00	EMPLOYEE BENEFITS	63,221	947,989	1,011,210	0	1,011,210	4.00
5.00	ADMINISTRATIVE & GENERAL	1,025,303	1,117,874	2,143,177	289,188	2,432,365	5.00
6.00	MAINTENANCE & REPAIRS	216,071	230,909	446,980	0	446,980	6.00
7.00	OPERATION OF PLANT	0	441,662	441,662	0	441,662	7.00
8.00	LAUNDRY & LINEN SERVICE	0	88,376	88,376	0	88,376	8.00
9.00	HOUSEKEEPING	183,619	38,177	221,796	0	221,796	9.00
10.00	DIETARY	354,133	348,243	702,376	-112,683	589,693	10.00
11.00	CAFETERIA	0	0	0	112,683	112,683	11.00
13.00	NURSING ADMINISTRATION	373,304	36,992	410,296	0	410,296	13.00
16.00	MEDICAL RECORDS & LIBRARY	138,683	52,944	191,627	0	191,627	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	599,853	83,365	683,218	-24,568	658,650	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	153,484	46,532	200,016	-12,477	187,539	50.00
53.00	ANESTHESIOLOGY	0	51,868	51,868	-2,097	49,771	53.00
54.00	RADIOLOGY - DIAGNOSTIC	484,518	190,170	674,688	-22,043	652,645	54.00
60.00	LABORATORY	399,619	504,889	904,508	-243,724	660,784	60.00
65.00	RESPIRATORY THERAPY	244,154	125,655	369,809	-13,853	355,956	65.00
66.00	PHYSICAL THERAPY	17,949	158,471	176,420	-1,437	174,983	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,991	39,634	107,625	397,168	504,793	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	141,047	375,162	516,209	-2,100	514,109	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,301,861	154,737	1,456,598	-21,093	1,435,505	88.00
88.01	RURAL HEALTH CLINIC II	359,592	54,523	414,115	-5,540	408,575	88.01
90.00	CLINIC	222,259	212,703	434,962	-1,691	433,271	90.00
90.01	WOUND CARE	2,969	3,592	6,561	-204	6,357	90.01
91.00	EMERGENCY	612,540	1,470,687	2,083,227	-45,762	2,037,465	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		309,419	309,419	-309,419	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,962,170	7,623,846	14,586,016	579	14,586,595	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0	0	194.00
194.01	UNASSIGNED SPACE	0	0	0	0	0	194.01
194.02	LEASED CLINICS	141,118	15,215	156,333	-183	156,150	194.02
194.03	MARKETING	55,888	26,647	82,535	-396	82,139	194.03
200.00	TOTAL (SUM OF LINES 118-199)	7,159,176	7,665,708	14,824,884	0	14,824,884	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	262,655		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	296,849		2.00
4.00	EMPLOYEE BENEFITS	0	1,011,210		4.00
5.00	ADMINISTRATIVE & GENERAL	-47,653	2,384,712		5.00
6.00	MAINTENANCE & REPAIRS	0	446,980		6.00
7.00	OPERATION OF PLANT	-102,693	338,969		7.00
8.00	LAUNDRY & LINEN SERVICE	0	88,376		8.00
9.00	HOUSEKEEPING	0	221,796		9.00
10.00	DIETARY	-261,260	328,433		10.00
11.00	CAFETERIA	-70,028	42,655		11.00
13.00	NURSING ADMINISTRATION	0	410,296		13.00
16.00	MEDICAL RECORDS & LIBRARY	0	191,627		16.00
17.00	SOCIAL SERVICE	0	0		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	658,650		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	187,539		50.00
53.00	ANESTHESIOLOGY	-40,028	9,743		53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	652,645		54.00
60.00	LABORATORY	-26,150	634,634		60.00
65.00	RESPIRATORY THERAPY	-40,500	315,456		65.00
66.00	PHYSICAL THERAPY	0	174,983		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	504,793		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	-6,560	507,549		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	1,435,505		88.00
88.01	RURAL HEALTH CLINIC II	0	408,575		88.01
90.00	CLINIC	-36,000	397,271		90.00
90.01	WOUND CARE	0	6,357		90.01
91.00	EMERGENCY	-377,979	1,659,486		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)	-1,008,851	13,577,744		118.00
	NONREIMBURSABLE COST CENTERS				
194.00	NON-REIMBURSABLE CLINIC	0	0		194.00
194.01	UNASSIGNED SPACE	0	0		194.01
194.02	LEASED CLINICS	0	156,150		194.02
194.03	MARKETING	0	82,139		194.03
200.00	TOTAL (SUM OF LINES 118-199)	-1,008,851	13,816,033		200.00

RECLASSIFICATIONS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/16/2012 9:44 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	56,814	55,869	1.00
	TOTALS		56,814	55,869	
	B - SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	397,168	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
	TOTALS		0	397,168	
	C - INTEREST				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,231	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	289,188	2.00
	TOTALS		0	309,419	
500.00	Grand Total: Increases		56,814	762,456	500.00

RECLASSIFICATIONS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/16/2012 9:44 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	56,814	55,869	0		1.00
	TOTALS		56,814	55,869			
	B - SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	24,568	0		1.00
2.00	OPERATING ROOM	50.00	0	12,477	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	2,097	0		3.00
4.00	RADIOLOGY - DIAGNOSTIC	54.00	0	22,043	0		4.00
5.00	LABORATORY	60.00	0	243,724	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	13,853	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	1,437	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,100	0		8.00
9.00	CLINIC	90.00	0	1,691	0		9.00
10.00	WOUND CARE	90.01	0	204	0		10.00
11.00	EMERGENCY	91.00	0	45,762	0		11.00
13.00	RURAL HEALTH CLINIC	88.00	0	21,093	0		13.00
14.00	RURAL HEALTH CLINIC II	88.01	0	5,540	0		14.00
15.00	LEASED CLINICS	194.02	0	183	0		15.00
16.00	MARKETING	194.03	0	396	0		16.00
	TOTALS		0	397,168			
	C - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	309,419	9		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	309,419			
500.00	Grand Total: Decreases		56,814	762,456			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/16/2012 9:44 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	18,401	0	0	0	0	1.00
2.00	Land Improvements	103,779	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,689,036	506,451	0	506,451	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,822,929	18,270	0	18,270	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,634,145	524,721	0	524,721	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,634,145	524,721	0	524,721	0	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	CAP REL COSTS-BLDG & FIXT	262,655	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	276,618	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	539,273	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/16/2012 9:44 am

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	18,401	0	1.00
2.00	Land Improvements	103,779	0	2.00
3.00	Buildings and Fixtures	11,195,487	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	4,841,199	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,158,866	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,158,866	0	10.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	262,655	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	276,618	2.00
3.00	Total (sum of lines 1-2)	0	539,273	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	262,655	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	296,849	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	559,504	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	262,655	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	296,849	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	559,504	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/16/2012 9:44 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - buildings and fixtures (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-6,722	ADMINISTRATIVE & GENERAL	5.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-47	ADMINISTRATIVE & GENERAL	5.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		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	-520,657			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-70,028	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients	B	-6,560	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	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 - buildings and fixtures		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	DIETARY	B	-200	DIETARY	10.00	33.00
33.01	MISC INCOME	B	-7,016	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	ADVERTISING	B	-3,659	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03			0		0.00	33.03
33.04	NON CAH MISC INCOME	B	-30,209	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05	BENTON DIETARY	B	-261,060	DIETARY	10.00	33.05
33.06	BENTON UTILITIES	A	-102,693	OPERATION OF PLANT	7.00	33.06
33.07			0		0.00	33.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,008,851			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/16/2012 9:44 am

		Wkst. A-7 Ref. 5.00		
1.00	Investment income - buildings and fixtures (chapter 2)	0		1.00
2.00	Investment income - movable equipment (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - buildings and fixtures	0		26.00
27.00	Depreciation - movable equipment	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	DIETARY	0		33.00
33.01	MISC INCOME	0		33.01
33.02	ADVERTISING	0		33.02
33.03		0		33.03
33.04	NON CAH MISC INCOME	0		33.04
33.05	BENTON DIETARY	0		33.05
33.06	BENTON UTILITIES	0		33.06
33.07		0		33.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2012 9:44 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		53.00	ANESTHESIA	40,028	40,028	1.00
2.00		60.00	LAB	26,150	26,150	2.00
3.00		65.00	SLEEP LAB	40,500	40,500	3.00
4.00		90.00	SENIOR CARE	36,000	36,000	4.00
5.00		91.00	ER	1,216,825	377,979	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00			TOTAL (lines 1.00 through 199.00)	1,359,503	520,657	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2012 9:44 am

		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		838,847	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		838,847		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2012 9:44 am

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/16/2012 9:44 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	40,028		1.00
2.00		0	26,150		2.00
3.00		0	40,500		3.00
4.00		0	36,000		4.00
5.00		0	377,979		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	520,657		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/16/2012 9:44 am
		Physical Therapy	Cost

							1.00	
	PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						259	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						194	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.50	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	1,560.71	810.21	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	57.85	57.85	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	28.93	28.93	28.93				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						90,287	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)						46,871	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						137,158	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						137,158	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						137,158	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
	Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						7,493	24.00
25.00	Assistants (line 4 times column 3, line 11)						5,612	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						13,105	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						2,492	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						15,597	28.00
	Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
	Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
	Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/16/2012 9:44 am
		Physical Therapy	Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	57.85	57.85	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	137,158		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	137,158		63.00
64.00	Total cost of outside supplier services (from your records)	127,195		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,105		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,492		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	15,597		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,492		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	2,492		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	262,655	262,655				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	296,849		296,849			2.00
4.00	EMPLOYEE BENEFITS	1,011,210	959	0	1,012,169		4.00
5.00	ADMINISTRATIVE & GENERAL	2,384,712	26,163	176	146,249	2,557,300	5.00
6.00	MAINTENANCE & REPAIRS	446,980	10,277	37,827	30,820	525,904	6.00
7.00	OPERATION OF PLANT	338,969	32,121	0	0	371,090	7.00
8.00	LAUNDRY & LINEN SERVICE	88,376	2,824	0	0	91,200	8.00
9.00	HOUSEKEEPING	221,796	907	0	26,191	248,894	9.00
10.00	DIETARY	328,433	18,676	2,978	42,410	392,497	10.00
11.00	CAFETERIA	42,655	0	0	8,104	50,759	11.00
13.00	NURSING ADMINISTRATION	410,296	1,278	0	53,248	464,822	13.00
16.00	MEDICAL RECORDS & LIBRARY	191,627	3,960	13,787	19,782	229,156	16.00
17.00	SOCIAL SERVICE	0	928	0	0	928	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	658,650	22,614	109,374	85,563	876,201	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	187,539	24,250	17,002	21,893	250,684	50.00
53.00	ANESTHESIOLOGY	9,743	389	166	0	10,298	53.00
54.00	RADIOLOGY - DIAGNOSTIC	652,645	10,398	30,595	69,112	762,750	54.00
60.00	LABORATORY	634,634	5,734	3,746	57,002	701,116	60.00
65.00	RESPIRATORY THERAPY	315,456	5,113	2,976	34,826	358,371	65.00
66.00	PHYSICAL THERAPY	174,983	4,940	256	2,560	182,739	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	504,793	9,534	387	9,698	524,412	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	507,549	4,016	6,240	20,119	537,924	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,435,505	26,513	31,870	185,700	1,679,588	88.00
88.01	RURAL HEALTH CLINIC II	408,575	5,713	38,479	51,292	504,059	88.01
90.00	CLINIC	397,271	10,635	757	31,703	440,366	90.00
90.01	WOUND CARE	6,357	0	0	423	6,780	90.01
91.00	EMERGENCY	1,659,486	9,608	233	87,373	1,756,700	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,577,744	237,550	296,849	984,068	13,524,538	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0	0	194.00
194.01	UNASSIGNED SPACE	0	397	0	0	397	194.01
194.02	LEASED CLINICS	156,150	24,708	0	20,129	200,987	194.02
194.03	MARKETING	82,139	0	0	7,972	90,111	194.03
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	13,816,033	262,655	296,849	1,012,169	13,816,033	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	2,557,300					5.00
6.00	MAINTENANCE & REPAIRS	119,453	645,357				6.00
7.00	OPERATION OF PLANT	84,289	92,029	547,408			7.00
8.00	LAUNDRY & LINEN SERVICE	20,715	8,091	8,004	128,010		8.00
9.00	HOUSEKEEPING	56,534	2,598	2,570	0	310,596	9.00
10.00	DIETARY	89,151	53,506	52,933	0	0	10.00
11.00	CAFETERIA	11,529	0	0	0	11,209	11.00
13.00	NURSING ADMINISTRATION	105,579	3,662	3,623	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	52,050	11,344	11,223	0	9,925	16.00
17.00	SOCIAL SERVICE	211	2,660	2,631	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	199,019	64,788	64,095	45,865	72,746	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	56,940	69,477	68,733	21,381	27,790	50.00
53.00	ANESTHESIOLOGY	2,339	1,113	1,101	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	173,250	29,790	29,471	21,977	10,392	54.00
60.00	LABORATORY	159,251	16,429	16,253	10,164	10,626	60.00
65.00	RESPIRATORY THERAPY	81,400	14,648	14,491	212	18,215	65.00
66.00	PHYSICAL THERAPY	41,507	14,153	14,001	2,242	8,407	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,114	27,316	27,023	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	122,184	11,505	11,382	0	9,925	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	381,500	75,959	75,150	248	56,865	88.00
88.01	RURAL HEALTH CLINIC II	114,491	16,367	16,192	0	0	88.01
90.00	CLINIC	100,024	30,470	30,144	386	0	90.00
90.01	WOUND CARE	1,540	0	0	0	0	90.01
91.00	EMERGENCY	399,020	27,526	27,231	25,535	48,574	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,491,090	573,431	476,251	128,010	284,674	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0	0	194.00
194.01	UNASSIGNED SPACE	90	1,138	1,126	0	0	194.01
194.02	LEASED CLINICS	45,652	70,788	70,031	0	25,922	194.02
194.03	MARKETING	20,468	0	0	0	0	194.03
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)	2,557,300	645,357	547,408	128,010	310,596	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	588,087					10.00
11.00	CAFETERIA	0	73,497				11.00
13.00	NURSING ADMINISTRATION	0	5,050	582,736			13.00
16.00	MEDICAL RECORDS & LIBRARY	0	3,837	0	317,535		16.00
17.00	SOCIAL SERVICE	0	0	0	0	6,430	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	588,087	14,284	302,744	18,557	6,430	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	1,859	39,397	8,731	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	416	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	10,586	0	84,402	0	54.00
60.00	LABORATORY	0	10,417	0	75,755	0	60.00
65.00	RESPIRATORY THERAPY	0	5,626	0	27,111	0	65.00
66.00	PHYSICAL THERAPY	0	10	0	8,695	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,988	0	1,697	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,266	0	25,927	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	209	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	298	0	0	0	88.01
90.00	CLINIC	0	4,731	0	16,914	0	90.00
90.01	WOUND CARE	0	0	0	200	0	90.01
91.00	EMERGENCY	0	11,352	240,595	49,130	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	588,087	72,513	582,736	317,535	6,430	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0	0	194.00
194.01	UNASSIGNED SPACE	0	0	0	0	0	194.01
194.02	LEASED CLINICS	0	0	0	0	0	194.02
194.03	MARKETING	0	984	0	0	0	194.03
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)	588,087	73,497	582,736	317,535	6,430	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	2,252,816	0	2,252,816		30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	544,992	0	544,992		50.00
53.00	ANESTHESIOLOGY	15,267	0	15,267		53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,122,618	0	1,122,618		54.00
60.00	LABORATORY	1,000,011	0	1,000,011		60.00
65.00	RESPIRATORY THERAPY	520,074	0	520,074		65.00
66.00	PHYSICAL THERAPY	271,754	0	271,754		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	701,550	0	701,550		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	721,113	0	721,113		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	2,269,519	0	2,269,519		88.00
88.01	RURAL HEALTH CLINIC II	651,407	0	651,407		88.01
90.00	CLINIC	623,035	0	623,035		90.00
90.01	WOUND CARE	8,520	0	8,520		90.01
91.00	EMERGENCY	2,585,663	0	2,585,663		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,288,339	0	13,288,339		118.00
	NONREIMBURSABLE COST CENTERS					
194.00	NON-REIMBURSABLE CLINIC	0	0	0		194.00
194.01	UNASSIGNED SPACE	2,751	0	2,751		194.01
194.02	LEASED CLINICS	413,380	0	413,380		194.02
194.03	MARKETING	111,563	0	111,563		194.03
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	13,816,033	0	13,816,033		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	959	0	959	959	4.00
5.00	ADMINISTRATIVE & GENERAL	0	26,163	176	26,339	138	5.00
6.00	MAINTENANCE & REPAIRS	0	10,277	37,827	48,104	29	6.00
7.00	OPERATION OF PLANT	0	32,121	0	32,121	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	2,824	0	2,824	0	8.00
9.00	HOUSEKEEPING	0	907	0	907	25	9.00
10.00	DIETARY	0	18,676	2,978	21,654	40	10.00
11.00	CAFETERIA	0	0	0	0	8	11.00
13.00	NURSING ADMINISTRATION	0	1,278	0	1,278	50	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	3,960	13,787	17,747	19	16.00
17.00	SOCIAL SERVICE	0	928	0	928	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	22,614	109,374	131,988	81	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	24,250	17,002	41,252	21	50.00
53.00	ANESTHESIOLOGY	0	389	166	555	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	10,398	30,595	40,993	65	54.00
60.00	LABORATORY	0	5,734	3,746	9,480	54	60.00
65.00	RESPIRATORY THERAPY	0	5,113	2,976	8,089	33	65.00
66.00	PHYSICAL THERAPY	0	4,940	256	5,196	2	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,534	387	9,921	9	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,016	6,240	10,256	19	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	26,513	31,870	58,383	177	88.00
88.01	RURAL HEALTH CLINIC II	0	5,713	38,479	44,192	49	88.01
90.00	CLINIC	0	10,635	757	11,392	30	90.00
90.01	WOUND CARE	0	0	0	0	0	90.01
91.00	EMERGENCY	0	9,608	233	9,841	83	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	237,550	296,849	534,399	932	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0	0	194.00
194.01	UNASSIGNED SPACE	0	397	0	397	0	194.01
194.02	LEASED CLINICS	0	24,708	0	24,708	19	194.02
194.03	MARKETING	0	0	0	0	8	194.03
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	262,655	296,849	559,504	959	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	26,477					5.00
6.00	MAINTENANCE & REPAIRS	1,237	49,370				6.00
7.00	OPERATION OF PLANT	873	7,040	40,034			7.00
8.00	LAUNDRY & LINEN SERVICE	215	619	585	4,243		8.00
9.00	HOUSEKEEPING	585	199	188	0	1,904	9.00
10.00	DIETARY	923	4,093	3,871	0	0	10.00
11.00	CAFETERIA	119	0	0	0	69	11.00
13.00	NURSING ADMINISTRATION	1,093	280	265	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	539	868	821	0	61	16.00
17.00	SOCIAL SERVICE	2	203	192	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,061	4,956	4,688	1,521	444	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	590	5,315	5,027	709	170	50.00
53.00	ANESTHESIOLOGY	24	85	81	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,794	2,279	2,155	728	64	54.00
60.00	LABORATORY	1,649	1,257	1,189	337	65	60.00
65.00	RESPIRATORY THERAPY	843	1,121	1,060	7	112	65.00
66.00	PHYSICAL THERAPY	430	1,083	1,024	74	52	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,233	2,090	1,976	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,265	880	832	0	61	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	3,950	5,811	5,495	8	349	88.00
88.01	RURAL HEALTH CLINIC II	1,186	1,252	1,184	0	0	88.01
90.00	CLINIC	1,036	2,331	2,205	13	0	90.00
90.01	WOUND CARE	16	0	0	0	0	90.01
91.00	EMERGENCY	4,128	2,106	1,992	846	298	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,791	43,868	34,830	4,243	1,745	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0	0	194.00
194.01	UNASSIGNED SPACE	1	87	82	0	0	194.01
194.02	LEASED CLINICS	473	5,415	5,122	0	159	194.02
194.03	MARKETING	212	0	0	0	0	194.03
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)	26,477	49,370	40,034	4,243	1,904	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	30,581					10.00
11.00	CAFETERIA	0	196				11.00
13.00	NURSING ADMINISTRATION	0	13	2,979			13.00
16.00	MEDICAL RECORDS & LIBRARY	0	10	0	20,065		16.00
17.00	SOCIAL SERVICE	0	0	0	0	1,325	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	30,581	38	1,548	1,172	1,325	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	5	201	551	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	26	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	28	0	5,341	0	54.00
60.00	LABORATORY	0	28	0	4,785	0	60.00
65.00	RESPIRATORY THERAPY	0	15	0	1,712	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	549	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5	0	107	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	6	0	1,638	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	1	0	0	0	88.01
90.00	CLINIC	0	13	0	1,068	0	90.00
90.01	WOUND CARE	0	0	0	13	0	90.01
91.00	EMERGENCY	0	30	1,230	3,103	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	30,581	193	2,979	20,065	1,325	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0	0	194.00
194.01	UNASSIGNED SPACE	0	0	0	0	0	194.01
194.02	LEASED CLINICS	0	0	0	0	0	194.02
194.03	MARKETING	0	3	0	0	0	194.03
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)	30,581	196	2,979	20,065	1,325	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	180,403	0	180,403		30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	53,841	0	53,841		50.00
53.00	ANESTHESIOLOGY	771	0	771		53.00
54.00	RADIOLOGY - DIAGNOSTIC	53,447	0	53,447		54.00
60.00	LABORATORY	18,844	0	18,844		60.00
65.00	RESPIRATORY THERAPY	12,992	0	12,992		65.00
66.00	PHYSICAL THERAPY	8,410	0	8,410		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,341	0	15,341		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	14,957	0	14,957		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	74,174	0	74,174		88.00
88.01	RURAL HEALTH CLINIC II	47,864	0	47,864		88.01
90.00	CLINIC	18,088	0	18,088		90.00
90.01	WOUND CARE	29	0	29		90.01
91.00	EMERGENCY	23,657	0	23,657		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	522,818	0	522,818		118.00
	NONREIMBURSABLE COST CENTERS					
194.00	NON-REIMBURSABLE CLINIC	0	0	0		194.00
194.01	UNASSIGNED SPACE	567	0	567		194.01
194.02	LEASED CLINICS	35,896	0	35,896		194.02
194.03	MARKETING	223	0	223		194.03
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	559,504	0	559,504		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	60,827					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		543,347				2.00
4.00	EMPLOYEE BENEFITS	222	0	7,095,955			4.00
5.00	ADMINISTRATIVE & GENERAL	6,059	322	1,025,303	-2,557,300	11,258,733	5.00
6.00	MAINTENANCE & REPAIRS	2,380	69,238	216,071	0	525,904	6.00
7.00	OPERATION OF PLANT	7,439	0	0	0	371,090	7.00
8.00	LAUNDRY & LINEN SERVICE	654	0	0	0	91,200	8.00
9.00	HOUSEKEEPING	210	0	183,619	0	248,894	9.00
10.00	DIETARY	4,325	5,450	297,319	0	392,497	10.00
11.00	CAFETERIA	0	0	56,814	0	50,759	11.00
13.00	NURSING ADMINISTRATION	296	0	373,304	0	464,822	13.00
16.00	MEDICAL RECORDS & LIBRARY	917	25,235	138,683	0	229,156	16.00
17.00	SOCIAL SERVICE	215	0	0	0	928	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,237	200,199	599,853	0	876,201	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,616	31,120	153,484	0	250,684	50.00
53.00	ANESTHESIOLOGY	90	303	0	0	10,298	53.00
54.00	RADIOLOGY - DIAGNOSTIC	2,408	56,000	484,518	0	762,750	54.00
60.00	LABORATORY	1,328	6,856	399,619	0	701,116	60.00
65.00	RESPIRATORY THERAPY	1,184	5,448	244,154	0	358,371	65.00
66.00	PHYSICAL THERAPY	1,144	468	17,949	0	182,739	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,208	709	67,991	0	524,412	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	930	11,422	141,047	0	537,924	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	6,140	58,334	1,301,861	0	1,679,588	88.00
88.01	RURAL HEALTH CLINIC II	1,323	70,431	359,592	0	504,059	88.01
90.00	CLINIC	2,463	1,385	222,259	0	440,366	90.00
90.01	WOUND CARE	0	0	2,969	0	6,780	90.01
91.00	EMERGENCY	2,225	427	612,540	0	1,756,700	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,013	543,347	6,898,949	-2,557,300	10,967,238	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0	0	194.00
194.01	UNASSIGNED SPACE	92	0	0	0	397	194.01
194.02	LEASED CLINICS	5,722	0	141,118	0	200,987	194.02
194.03	MARKETING	0	0	55,888	0	90,111	194.03
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)	262,655	296,849	1,012,169		2,557,300	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.318066	0.546334	0.142640		0.227139	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			959		26,477	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000135		0.002352	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	52,166					6.00
7.00	OPERATION OF PLANT	7,439	44,727				7.00
8.00	LAUNDRY & LINEN SERVICE	654	654	104,701			8.00
9.00	HOUSEKEEPING	210	210	0	2,660		9.00
10.00	DIETARY	4,325	4,325	0	0	7,549	10.00
11.00	CAFETERIA	0	0	0	96	0	11.00
13.00	NURSING ADMINISTRATION	296	296	0	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	917	917	0	85	0	16.00
17.00	SOCIAL SERVICE	215	215	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,237	5,237	37,514	623	7,549	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,616	5,616	17,488	238	0	50.00
53.00	ANESTHESIOLOGY	90	90	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	2,408	2,408	17,975	89	0	54.00
60.00	LABORATORY	1,328	1,328	8,313	91	0	60.00
65.00	RESPIRATORY THERAPY	1,184	1,184	173	156	0	65.00
66.00	PHYSICAL THERAPY	1,144	1,144	1,834	72	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,208	2,208	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	930	930	0	85	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	6,140	6,140	203	487	0	88.00
88.01	RURAL HEALTH CLINIC II	1,323	1,323	0	0	0	88.01
90.00	CLINIC	2,463	2,463	316	0	0	90.00
90.01	WOUND CARE	0	0	0	0	0	90.01
91.00	EMERGENCY	2,225	2,225	20,885	416	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	46,352	38,913	104,701	2,438	7,549	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0	0	194.00
194.01	UNASSIGNED SPACE	92	92	0	0	0	194.01
194.02	LEASED CLINICS	5,722	5,722	0	222	0	194.02
194.03	MARKETING	0	0	0	0	0	194.03
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)	645,357	547,408	128,010	310,596	588,087	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.371219	12.238871	1.222624	116.765414	77.902636	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	49,370	40,034	4,243	1,904	30,581	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.946402	0.895075	0.040525	0.715789	4.051000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		11.00	13.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	7,394					11.00
13.00	NURSING ADMINISTRATION	508	2,766				13.00
16.00	MEDICAL RECORDS & LIBRARY	386	0	23,934,113			16.00
17.00	SOCIAL SERVICE	0	0	0	100		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,437	1,437	1,398,767	100		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	187	187	658,064	0		50.00
53.00	ANESTHESIOLOGY	0	0	31,361	0		53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,065	0	6,361,737	0		54.00
60.00	LABORATORY	1,048	0	5,709,999	0		60.00
65.00	RESPIRATORY THERAPY	566	0	2,043,504	0		65.00
66.00	PHYSICAL THERAPY	1	0	655,420	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	200	0	127,913	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	228	0	1,954,217	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	21	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	30	0	0	0		88.01
90.00	CLINIC	476	0	1,274,907	0		90.00
90.01	WOUND CARE	0	0	15,055	0		90.01
91.00	EMERGENCY	1,142	1,142	3,703,169	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,295	2,766	23,934,113	100		118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE CLINIC	0	0	0	0		194.00
194.01	UNASSIGNED SPACE	0	0	0	0		194.01
194.02	LEASED CLINICS	0	0	0	0		194.02
194.03	MARKETING	99	0	0	0		194.03
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)	73,497	582,736	317,535	6,430		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.940087	210.678236	0.013267	64.300000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	196	2,979	20,065	1,325		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.026508	1.077007	0.000838	13.250000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/16/2012 9:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,252,816		2,252,816	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	544,992		544,992	0	0	50.00
53.00	ANESTHESIOLOGY	15,267		15,267	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,122,618		1,122,618	0	0	54.00
60.00	LABORATORY	1,000,011		1,000,011	0	0	60.00
65.00	RESPIRATORY THERAPY	520,074	0	520,074	0	0	65.00
66.00	PHYSICAL THERAPY	271,754	0	271,754	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	701,550		701,550	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	721,113		721,113	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	2,269,519		2,269,519	0	0	88.00
88.01	RURAL HEALTH CLINIC II	651,407		651,407	0	0	88.01
90.00	CLINIC	623,035		623,035	0	0	90.00
90.01	WOUND CARE	8,520		8,520	0	0	90.01
91.00	EMERGENCY	2,585,663		2,585,663	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	225,282		225,282		0	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	13,513,621	0	13,513,621	0	0	200.00
201.00	Less Observation Beds	225,282		225,282		0	201.00
202.00	Total (see instructions)	13,288,339	0	13,288,339	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/16/2012 9:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,237,351		1,237,351			30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,756	655,308	658,064	0.828175	0.000000	50.00
53.00	ANESTHESIOLOGY	113	0	113	135.106195	0.000000	53.00
54.00	RADIOLOGY - DIAGNOSTIC	255,186	6,106,551	6,361,737	0.176464	0.000000	54.00
60.00	LABORATORY	437,086	5,272,913	5,709,999	0.175133	0.000000	60.00
65.00	RESPIRATORY THERAPY	373,679	1,371,021	1,744,700	0.298088	0.000000	65.00
66.00	PHYSICAL THERAPY	115,671	539,750	655,421	0.414625	0.000000	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	247,638	179,078	426,716	1.644068	0.000000	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	670,796	1,283,420	1,954,216	0.369004	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,485,518	1,485,518			88.00
88.01	RURAL HEALTH CLINIC II	0	285,988	285,988			88.01
90.00	CLINIC	0	1,274,907	1,274,907	0.488691	0.000000	90.00
90.01	WOUND CARE	0	15,055	15,055	0.565925	0.000000	90.01
91.00	EMERGENCY	22,132	3,681,037	3,703,169	0.698230	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	52	161,364	161,416	1.395661	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	3,362,460	22,311,910	25,674,370			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	3,362,460	22,311,910	25,674,370			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Hospital	Cost

	Cost Center Description	PPS Inpatient Ratio		
		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
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC			88.00
88.01	RURAL HEALTH CLINIC II			88.01
90.00	CLINIC	0.000000		90.00
90.01	WOUND CARE	0.000000		90.01
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: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D Part II Date/Time Prepared: 1/16/2012 9:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	53,841	658,064	0.081817	2,756	225	50.00
53.00	ANESTHESIOLOGY	771	113	6.823009	113	771	53.00
54.00	RADIOLOGY - DIAGNOSTIC	53,447	6,361,737	0.008401	188,843	1,586	54.00
60.00	LABORATORY	18,844	5,709,999	0.003300	383,718	1,266	60.00
65.00	RESPIRATORY THERAPY	12,992	1,744,700	0.007447	294,963	2,197	65.00
66.00	PHYSICAL THERAPY	8,410	655,421	0.012831	56,703	728	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,341	426,716	0.035951	181,107	6,511	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	14,957	1,954,216	0.007654	497,585	3,809	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	74,174	1,485,518	0.049931	0	0	88.00
88.01	RURAL HEALTH CLINIC II	47,864	285,988	0.167364	0	0	88.01
90.00	CLINIC	18,088	1,274,907	0.014188	0	0	90.00
90.01	WOUND CARE	29	15,055	0.001926	0	0	90.01
91.00	EMERGENCY	23,657	3,703,169	0.006388	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	161,416	0.000000	52	0	92.00
200.00	Total (lines 50-199)	342,415	24,437,019		1,605,840	17,093	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Hospital	Cost

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
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
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	CLINIC	0	0	0	0	0	90.00
90.01	WOUND CARE	0	0	0	0	0	90.01
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: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/16/2012 9:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	658,064	0.000000	0.000000	2,756	50.00
53.00	ANESTHESIOLOGY	0	113	0.000000	0.000000	113	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	6,361,737	0.000000	0.000000	188,843	54.00
60.00	LABORATORY	0	5,709,999	0.000000	0.000000	383,718	60.00
65.00	RESPIRATORY THERAPY	0	1,744,700	0.000000	0.000000	294,963	65.00
66.00	PHYSICAL THERAPY	0	655,421	0.000000	0.000000	56,703	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	426,716	0.000000	0.000000	181,107	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,954,216	0.000000	0.000000	497,585	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,485,518	0.000000	0.000000	0	88.00
88.01	RURAL HEALTH CLINIC II	0	285,988	0.000000	0.000000	0	88.01
90.00	CLINIC	0	1,274,907	0.000000	0.000000	0	90.00
90.01	WOUND CARE	0	15,055	0.000000	0.000000	0	90.01
91.00	EMERGENCY	0	3,703,169	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	161,416	0.000000	0.000000	52	92.00
200.00	Total (lines 50-199)	0	24,437,019			1,605,840	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/16/2012 9:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
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
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	CLINIC	0	0	0		90.00
90.01	WOUND CARE	0	0	0		90.01
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: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/16/2012 9:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.828175	0	327,787	0		50.00
53.00	ANESTHESIOLOGY	135.106195	0	0	0		53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.176464	0	2,206,727	0		54.00
60.00	LABORATORY	0.175133	0	2,320,011	0		60.00
65.00	RESPIRATORY THERAPY	0.298088	0	585,020	0		65.00
66.00	PHYSICAL THERAPY	0.414625	0	234,844	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.644068	0	104,688	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.369004	0	727,241	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
90.00	CLINIC	0.488691	0	1,264,090	0		90.00
90.01	WOUND CARE	0.565925	0	0	0		90.01
91.00	EMERGENCY	0.698230	0	1,170,269	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.395661	0	118,464	0		92.00
200.00	Subtotal (see instructions)		0	9,059,141	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	9,059,141	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/16/2012 9:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Costs PPS Services (see instructions)	Costs Cost Services Subject To Ded. & Coins. (see instructions)	Costs Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	271,465	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	389,408	0		54.00
60.00	LABORATORY	0	406,310	0		60.00
65.00	RESPIRATORY THERAPY	0	174,387	0		65.00
66.00	PHYSICAL THERAPY	0	97,372	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	172,114	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	268,355	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
90.00	CLINIC	0	617,749	0		90.00
90.01	WOUND CARE	0	0	0		90.01
91.00	EMERGENCY	0	817,117	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	165,336	0		92.00
200.00	Subtotal (see instructions)	0	3,379,613	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	3,379,613	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/16/2012 9:44 am

Component CCN: 14Z321 | Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.828175	0	0	0		50.00
53.00	ANESTHESIOLOGY	135.106195	0	0	0		53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.176464	0	0	0		54.00
60.00	LABORATORY	0.175133	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0.298088	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.414625	0	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.644068	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.369004	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
90.00	CLINIC	0.488691	0	0	0		90.00
90.01	WOUND CARE	0.565925	0	0	0		90.01
91.00	EMERGENCY	0.698230	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.395661	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: 141321 | Component CCN: 14Z321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/16/2012 9:44 am

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
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
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	CLINIC	0	0	0		90.00
90.01	WOUND CARE	0	0	0		90.01
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: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/16/2012 9:44 am

Title XIX | Hospital

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.000000	0	0	40,387		50.00
53.00	ANESTHESIOLOGY	0.000000	0	0	0		53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000	0	0	1,592,891		54.00
60.00	LABORATORY	0.000000	0	0	1,158,520		60.00
65.00	RESPIRATORY THERAPY	0.000000	0	0	241,501		65.00
66.00	PHYSICAL THERAPY	0.000000	0	0	117,272		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	26,291		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	0	0	210,188		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
90.00	CLINIC	0.000000	0	0	96,593		90.00
90.01	WOUND CARE	0.000000	0	0	3,233		90.01
91.00	EMERGENCY	0.000000	0	0	1,222,588		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	11,068		92.00
200.00	Subtotal (see instructions)		0	0	4,720,532		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	4,720,532		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/16/2012 9:44 am

Title XIX | Hospital

	Cost Center Description	Costs PPS Services (see instructions)	Costs Cost Services Subject To Ded. & Coins. (see instructions)	Costs Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
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
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	CLINIC	0	0	0		90.00
90.01	WOUND CARE	0	0	0		90.01
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: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,620	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,391	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)	1,391	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	115	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)	114	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,086	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)	115	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)	114	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,252,816	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	318,454	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,934,362	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,237,351	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,237,351	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.563309	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)	889.54	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,934,362	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)	1,390.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,510,224	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)	1,510,224	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/16/2012 9:44 am

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)	710,946	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,221,170	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)	159,922	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	158,532	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	318,454	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)	162	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,390.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	225,282	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Hospital	Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/16/2012 9:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		931,230		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.828175	2,756	2,282	50.00
53.00	ANESTHESIOLOGY	135.106195	113	15,267	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.176464	188,843	33,324	54.00
60.00	LABORATORY	0.175133	383,718	67,202	60.00
65.00	RESPIRATORY THERAPY	0.298088	294,963	87,925	65.00
66.00	PHYSICAL THERAPY	0.414625	56,703	23,510	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.644068	181,107	297,752	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.369004	497,585	183,611	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
90.00	CLINIC	0.488691	0	0	90.00
90.01	WOUND CARE	0.565925	0	0	90.01
91.00	EMERGENCY	0.698230	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.395661	52	73	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,605,840	710,946	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,605,840		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141321 | Component CCN: 14Z321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/16/2012 9:44 am

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	0.828175	0	0	50.00
53.00	ANESTHESIOLOGY	135.106195	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.176464	9,184	1,621	54.00
60.00	LABORATORY	0.175133	25,476	4,462	60.00
65.00	RESPIRATORY THERAPY	0.298088	31,416	9,365	65.00
66.00	PHYSICAL THERAPY	0.414625	46,010	19,077	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.644068	40,461	66,521	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.369004	74,897	27,637	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
90.00	CLINIC	0.488691	0	0	90.00
90.01	WOUND CARE	0.565925	0	0	90.01
91.00	EMERGENCY	0.698230	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.395661	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		227,444	128,683	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)		227,444		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/16/2012 9:44 am

Title XIX | Hospital

	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		38,311		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000	0	0	50.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000	31,756	0	54.00
60.00	LABORATORY	0.000000	20,860	0	60.00
65.00	RESPIRATORY THERAPY	0.000000	11,735	0	65.00
66.00	PHYSICAL THERAPY	0.000000	246	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	870	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	31,053	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
90.00	CLINIC	0.000000	0	0	90.00
90.01	WOUND CARE	0.000000	0	0	90.01
91.00	EMERGENCY	0.000000	7,220	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		103,740	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)		103,740		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,379,613	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,379,613	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,413,409	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)	22,401	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,351,948	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)	2,039,060	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)	2,039,060	30.00
31.00	Primary payer payments	638	31.00
32.00	Subtotal (line 30 minus line 31)	2,038,422	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)	348,623	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	348,623	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	348,623	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,387,045	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,387,045	40.00
41.00	Interim payments	3,050,611	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)	-663,566	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: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/16/2012 9:44 am

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		2,434,921		2,732,248	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		23,062		408,774	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	03/04/2011	16,252		0	3.01
3.02		06/24/2011	8,188		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		0	03/04/2011	58,461	3.50
3.51			0	06/24/2011	31,950	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)		24,440		-90,411	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)		2,482,423		3,050,611	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		419,597		663,566	6.02
7.00	Total Medicare program liability (see instructions)		2,062,826		2,387,045	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: 141321 | Component CCN: 14Z321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/16/2012 9:44 am

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		533,763		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	03/04/2011	9,324		0	3.01
3.02		06/24/2011	4,381		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		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		13,705		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)		547,468		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		96,134		0	6.02
7.00	Total Medicare program liability (see instructions)		451,334		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: 141321 Component CCN: 14Z321	Period: From 07/31/2010 To 06/30/2011	Worksheet E-2 Date/Time Prepared: 1/16/2012 9:44 am
	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)	321,639	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)	129,970	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	229	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)	451,609	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	451,609	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)	451,609	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	275	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)	451,334	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)	451,334	0	19.00
20.00	Interim payments	547,468	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)	-96,134	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,221,170	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,221,170	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)	2,243,382	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,243,382	19.00
20.00	Deductibles (exclude professional component)	207,230	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)	2,036,152	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,036,152	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	26,674	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	26,674	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,674	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))	2,062,826	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)	2,062,826	30.00
31.00	Interim payments	2,482,423	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)	-419,597	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet G | Date/Time Prepared: 1/16/2012 9:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	501,937	0	0	0	1.00
2.00	Temporary investments	182,748	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,584,916	0	0	0	4.00
5.00	Other receivable	-200,226	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,671,071	0	0	0	6.00
7.00	Inventory	204,579	0	0	0	7.00
8.00	Prepaid expenses	29,706	0	0	0	8.00
9.00	Other current assets	558,716	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,191,305	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	16,158,866	0	0	0	15.00
16.00	Accumulated depreciation	-13,633,800	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)	2,525,066	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	14,008	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,008	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	6,730,379	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,803,685	0	0	0	37.00
38.00	Salaries, wages, and fees payable	828,092	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	929,663	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,010,057	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,571,497	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	3,585,403	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,585,403	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	8,156,900	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,426,521				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,426,521	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,730,379	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/16/2012 9:44 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		-1,068,636		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-21,830				2.00
3.00	Total (sum of line 1 and line 2)		-1,090,466		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,090,466		0		11.00
12.00	Deductions (debit adjustments) (specify)	336,055		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)		336,055		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,426,521		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/16/2012 9:44 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141321 | Period: From 07/31/2010 To 06/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 1/16/2012 9:44 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,237,351		1,237,351	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,237,351		1,237,351	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,237,351		1,237,351	17.00
18.00	Ancillary services	2,125,055	20,571,705	22,696,760	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,485,518	1,485,518	20.00
20.01	RURAL HEALTH CLINIC II	0	285,988	285,988	20.01
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	OTHER (SPECIFY)	8,358	1,466,132	1,474,490	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,370,764	23,809,343	27,180,107	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,824,884		29.00
30.00	ADD (SPECIFY)	0			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)		0		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)		14,824,884		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141321	Period: From 07/31/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/16/2012 9:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	27,180,107	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,842,279	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,337,828	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,824,884	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,487,056	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 (SPECIFY)	1,465,226	24.00
25.00	Total other income (sum of lines 6-24)	1,465,226	25.00
26.00	Total (line 5 plus line 25)	-21,830	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)	-21,830	29.00

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

Provider CCN: 141321 | Component CCN: 143469 | Period: From 07/31/2010 To 06/30/2011 | Worksheet M-1 | Date/Time Prepared: 1/16/2012 9:44 am

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	577,423	0	577,423	0	577,423	1.00
2.00	Physician Assistant	89,207	0	89,207	0	89,207	2.00
3.00	Nurse Practitioner	212,253	0	212,253	0	212,253	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	361,403	0	361,403	0	361,403	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	1,240,286	0	1,240,286	0	1,240,286	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	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,240,286	0	1,240,286	0	1,240,286	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	61,575	154,737	216,312	-21,093	195,219	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	61,575	154,737	216,312	-21,093	195,219	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,301,861	154,737	1,456,598	-21,093	1,435,505	32.00

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

Provider CCN: 141321	Period: From 07/31/2010	Worksheet M-1
Component CCN: 143469	To 06/30/2011	Date/Time Prepared: 1/16/2012 9:44 am
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	577,423		1.00
2.00	Physician Assistant	0	89,207		2.00
3.00	Nurse Practitioner	0	212,253		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	361,403		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	1,240,286		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	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,240,286		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	195,219		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	195,219		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,435,505		32.00

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

Provider CCN: 141321 | Component CCN: 148510 | Period: From 07/31/2010 To 06/30/2011 | Worksheet M-1 | Date/Time Prepared: 1/16/2012 9:44 am

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	171,347	0	171,347	0	171,347	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	103,918	0	103,918	0	103,918	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	43,214	0	43,214	0	43,214	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	318,479	0	318,479	0	318,479	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	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	318,479	0	318,479	0	318,479	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	41,113	54,523	95,636	-5,540	90,096	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	41,113	54,523	95,636	-5,540	90,096	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	359,592	54,523	414,115	-5,540	408,575	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141321 Component CCN: 148510	Period: From 07/31/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 1/16/2012 9:44 am
	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	171,347		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	103,918		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	43,214		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	318,479		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	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	318,479		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	90,096		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	90,096		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	408,575		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES	Provider CCN: 141321 Component CCN: 143469	Period: From 07/31/2010 To 06/30/2011	Worksheet M-2 Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.91	4,352	4,200	8,022		1.00
2.00	Physician Assistant	0.20	2,583	2,100	420		2.00
3.00	Nurse Practitioner	1.94	6,068	2,100	4,074		3.00
4.00	Subtotal (sum of lines 1-3)	4.05	13,003		12,516	13,003	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)	4.05	13,003			13,003	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)					1,240,286	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,240,286	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					195,219	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					834,014	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,029,233	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,029,233	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,029,233	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,269,519	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 141321 | Component CCN: 148510 | Period: From 07/31/2010 To 06/30/2011 | Worksheet M-2 | Date/Time Prepared: 1/16/2012 9:44 am

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	0.21	875	4,200	882		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.50	1,711	2,100	1,050		3.00
4.00	Subtotal (sum of lines 1-3)	0.71	2,586		1,932	2,586	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)	0.71	2,586			2,586	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)					318,479	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					318,479	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					90,096	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					242,832	15.00
16.00	Total overhead (sum of lines 14 and 15)					332,928	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					332,928	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					332,928	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					651,407	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141321 Component CCN: 143469	Period: From 07/31/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 1/16/2012 9:44 am
	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)		2,269,519	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,269,519	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		13,003	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)		13,003	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		174.54	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	174.54	174.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,791	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	487,141	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	487,141	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 line 16.03) times 80%)		358,254	16.04
16.05	Total program cost (see instructions)	0	358,254	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		39,324	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)		358,254	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		358,254	22.00
23.00	Reimbursable bad debts (see instructions)		14,740	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		14,740	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)		372,994	26.00
27.00	Interim payments		312,563	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)		60,431	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: 141321 Component CCN: 148510	Period: From 07/31/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		651,407	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		651,407	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,586	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)		2,586	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		251.90	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	251.90	251.90	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	418	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	105,294	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	105,294	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 line 16.03) times 80%)		82,342	16.04
16.05	Total program cost (see instructions)	0	82,342	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		2,367	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)		82,342	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		82,342	22.00
23.00	Reimbursable bad debts (see instructions)		2,456	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		2,456	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)		84,798	26.00
27.00	Interim payments		48,434	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)		36,364	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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141321 Component CCN: 143469	Period: From 07/31/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		303,900	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		03/04/2011	8,663	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)		8,663	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		312,563	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		60,431	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		372,994	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: 141321 Component CCN: 148510	Period: From 07/31/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 1/16/2012 9:44 am
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		48,434	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)		48,434	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		36,364	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		84,798	7.00

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