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: 141327

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/25/2012 9:06 am

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 5/25/2012 Time: 9:06 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: 04
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 WABASH GENERAL HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	965,835	360,454	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	66,973	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		280		0	10.00
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	1,032,808	360,734	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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2012 8:42 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1418 COLLEGE DRIVE	PO Box:			1.00
2.00	City: MT. CARMEL	State: IL	Zip Code: 62863-	County: WABASH	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	WABASH GENERAL HOSPITAL	141327	14999	1	06/01/2003	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	WABASH GENERAL HOSPITAL SWING BEDS	14Z327	14999		06/01/2003	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	WABASH GENERAL RHC	148501	14999		04/01/2009	N	O	N	15.00
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)	01/01/2011	12/31/2011	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	2	N	23.00

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

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	2		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141327	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/25/2012 8:42 am

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

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

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	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	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2012 8:42 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000	65.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2012 8:42 am

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(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
	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	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	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		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.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00

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

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

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

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

		Part A	Part B	
		1.00	2.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)			
155.00	Hospital	N	N	155.00
156.00	Subprovider - IPF	N	N	156.00
157.00	Subprovider - IRF	N	N	157.00
158.00	SUBPROVIDER	N	N	158.00
159.00	SNF	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	160.00
161.00	CMHC		N	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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2012 8:42 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.	Y	C	05/15/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	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	04/10/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2012 8:42 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.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N/A		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N/A		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N/A		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N/A		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/25/2012 8:42 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	04/10/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2012 8:42 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	21	7,665	60,240.00		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)		21	7,665	60,240.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	1,872.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	62,112.00		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
26.25	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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2012 8:42 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	1,953	112	2,510		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	329	0	329		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	54		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,282	112	2,893		7.00
8.00	INTENSIVE CARE UNIT	0	40	0	74		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	2,322	112	2,967		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	303	0	5,263		26.00
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	551		28.00
29.00	Ambulance Trips		800				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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2012 8:42 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	512	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	195.85	0.00	0	512	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	2.17	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	198.02	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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2012 8:42 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)	46	716		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)	46	716		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
26.25	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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2012 8:42 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	269,795	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)	3,255,812	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)	0	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	106,197	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	759,425	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,849	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	14,303	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,424,381	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: 141327 Component CCN: 148501 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-8 | Date/Time Prepared: 5/25/2012 8:42 am

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			1418 COLLEGE DRIVE		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	MT.CARMEL		IL	62863	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	12:00	21:00	18:00	21:00		11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	Provider name, CCN number					14.00

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

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

Provider CCN: 141327 Component CCN: 148501

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

Worksheet S-8

Date/Time Prepared: 5/25/2012 8:42 am

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		WABASH				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	18:00	21:00	18:00	21:00		11.00

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

Provider CCN: 141327 Component CCN: 148501

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

Worksheet S-8

Date/Time Prepared: 5/25/2012 8:42 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	18:00	21:00	18:00	21:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141327 Component CCN: 148501	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/25/2012 8:42 am
		Rural Health Clinic (RHC) I	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	12:00	21:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-10 | Date/Time Prepared: 5/25/2012 8:42 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)	0.463498	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,688,519	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	8,139,426	6.00
7.00	Medicaid cost (line 1 times line 6)	3,772,608	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,084,089	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,084,089	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	343,759	0	343,759	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	159,332	0	159,332	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	159,332	0	159,332	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)	3,953,528	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	250,352	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,703,176	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,716,415	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,875,747	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,959,836	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/25/2012 8:42 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	NEW CAP REL COSTS-BLDG & FIXT		510,702	510,702	0	510,702	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		664,812	664,812	648,701	1,313,513	2.00
4.00	EMPLOYEE BENEFITS	140,689	4,795,057	4,935,746	0	4,935,746	4.00
5.00	ADMINISTRATIVE & GENERAL	955,586	2,226,827	3,182,413	55,161	3,237,574	5.00
7.00	OPERATION OF PLANT	147,763	634,100	781,863	28,860	810,723	7.00
9.00	HOUSEKEEPING	221,475	50,796	272,271	0	272,271	9.00
10.00	DIETARY	319,616	220,024	539,640	-371,819	167,821	10.00
11.00	CAFETERIA	0	0	0	370,707	370,707	11.00
13.00	NURSING ADMINISTRATION	176,972	12,233	189,205	0	189,205	13.00
16.00	MEDICAL RECORDS & LIBRARY	284,852	54,052	338,904	0	338,904	16.00
17.00	SOCIAL SERVICE	124,892	12,628	137,520	0	137,520	17.00
19.00	NONPHYSICIAN ANESTHETISTS	806,245	24,066	830,311	-5,503	824,808	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,170,163	363,975	1,534,138	-51,865	1,482,273	30.00
31.00	INTENSIVE CARE UNIT	254,144	4,566	258,710	-2,230	256,480	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	625,788	343,453	969,241	-73,041	896,200	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	584,188	916,291	1,500,479	-115,968	1,384,511	54.00
60.00	LABORATORY	633,333	612,709	1,246,042	-58,813	1,187,229	60.00
65.00	RESPIRATORY THERAPY	403,630	167,778	571,408	-16,949	554,459	65.00
66.00	PHYSICAL THERAPY	501,684	35,141	536,825	-1,371	535,454	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	100,312	1,734,848	1,835,160	-1,016,400	818,760	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,210,192	1,210,192	72.00
73.00	DRUGS CHARGED TO PATIENTS	316,712	1,048,829	1,365,541	-4,461	1,361,080	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	179,467	7,006	186,473	-1,843	184,630	88.00
90.00	CLINIC	153,942	159,138	313,080	-19,841	293,239	90.00
90.01	ORTHOPAEDIC CLINIC	1,110,140	187,900	1,298,040	-33,249	1,264,791	90.01
90.02	SURGICAL CLINIC	781,680	171,137	952,817	-38,253	914,564	90.02
90.03	OP CLINIC	14,956	1,241	16,197	0	16,197	90.03
91.00	EMERGENCY	923,309	1,473,401	2,396,710	-45,644	2,351,066	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	438,444	83,535	521,979	-17,294	504,685	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		378,376	378,376	-378,376	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,369,982	16,894,621	28,264,603	60,701	28,325,304	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	358,892	542,417	901,309	-60,701	840,608	192.00
200.00	TOTAL (SUM OF LINES 118-199)	11,728,874	17,437,038	29,165,912	0	29,165,912	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	510,702		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-85,556	1,227,957		2.00
4.00	EMPLOYEE BENEFITS	-982,479	3,953,267		4.00
5.00	ADMINISTRATIVE & GENERAL	-225,077	3,012,497		5.00
7.00	OPERATION OF PLANT	0	810,723		7.00
9.00	HOUSEKEEPING	0	272,271		9.00
10.00	DIETARY	-21,756	146,065		10.00
11.00	CAFETERIA	-88,566	282,141		11.00
13.00	NURSING ADMINISTRATION	0	189,205		13.00
16.00	MEDICAL RECORDS & LIBRARY	-11,494	327,410		16.00
17.00	SOCIAL SERVICE	0	137,520		17.00
19.00	NONPHYSICIAN ANESTHETISTS	-806,245	18,563		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,482,273		30.00
31.00	INTENSIVE CARE UNIT	0	256,480		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	896,200		50.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-14,170	1,370,341		54.00
60.00	LABORATORY	-6,977	1,180,252		60.00
65.00	RESPIRATORY THERAPY	-107,830	446,629		65.00
66.00	PHYSICAL THERAPY	0	535,454		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-5,928	812,832		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,210,192		72.00
73.00	DRUGS CHARGED TO PATIENTS	-313	1,360,767		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	184,630		88.00
90.00	CLINIC	-120,800	172,439		90.00
90.01	ORTHOPAEDIC CLINIC	-863,843	400,948		90.01
90.02	SURGICAL CLINIC	-627,680	286,884		90.02
90.03	OP CLINIC	0	16,197		90.03
91.00	EMERGENCY	-951,331	1,399,735		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	504,685		95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-4,920,045	23,405,259		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	840,608		192.00
200.00	TOTAL (SUM OF LINES 118-199)	-4,920,045	24,245,867		200.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/25/2012 8:42 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENT					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	270,325		1.00
4.00		0.00	0	0		4.00
7.00		0.00	0	0		7.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
	TOTALS		0	270,325		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	219,561	151,146		1.00
	TOTALS		219,561	151,146		
	C - IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,808		1.00
	TOTALS		0	5,808		
	D - MATERIAL MANAGEMENT					
1.00	ADMINISTRATIVE & GENERAL	5.00	55,161	0		1.00
	TOTALS		55,161	0		
	E - INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	378,376		1.00
	TOTALS		0	378,376		
	F - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,873		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	7,873		
	G - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	246,888		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
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	TOTALS		0	246,888		
	H - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	28,860		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	28,860		
	I - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,210,192		1.00
	TOTALS		0	1,210,192		
500.00	Grand Total: Increases		274,722	2,299,468		500.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/25/2012 8:42 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00		0.00	0	0	9		1.00
4.00	DIETARY	10.00	0	1,112	0		4.00
7.00	ADULTS & PEDIATRICS	30.00	0	688	0		7.00
9.00	OPERATING ROOM	50.00	0	25,725	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	106,863	0		10.00
11.00	LABORATORY	60.00	0	19,761	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	7,560	0		12.00
15.00	ORTHOPAEDIC CLINIC	90.01	0	26,522	0		15.00
16.00	SURGICAL CLINIC	90.02	0	31,152	0		16.00
18.00	AMBULANCE SERVICES	95.00	0	12,000	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	38,942	0		19.00
	TOTALS		0	270,325			
	B - CAFETERIA						
1.00	DIETARY	10.00	219,561	151,146	0		1.00
	TOTALS		219,561	151,146			
	C - IV SOLUTIONS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,808	0		1.00
	TOTALS		0	5,808			
	D - MATERIAL MANAGEMENT						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	55,161	0	0		1.00
	TOTALS		55,161	0			
	E - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	378,376	9		1.00
	TOTALS		0	378,376			
	F - OXYGEN						
1.00	OPERATING ROOM	50.00	0	60	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	7,059	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	754	0		3.00
	TOTALS		0	7,873			
	G - MED SUPPLIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	5,503	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	51,177	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	2,230	0		3.00
4.00	OPERATING ROOM	50.00	0	47,256	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,105	0		5.00
6.00	LABORATORY	60.00	0	39,052	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	2,330	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	1,371	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,269	0		9.00
10.00	CLINIC	90.00	0	19,841	0		10.00
11.00	ORTHOPAEDIC CLINIC	90.01	0	6,727	0		11.00
12.00	EMERGENCY	91.00	0	45,644	0		12.00
13.00	RURAL HEALTH CLINIC	88.00	0	1,843	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	4,540	0		14.00
	TOTALS		0	246,888			
	H - UTILITIES						
1.00	SURGICAL CLINIC	90.02	0	7,101	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	21,759	0		2.00
	TOTALS		0	28,860			
	I - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,210,192	0		1.00
	TOTALS		0	1,210,192			
500.00	Grand Total: Decreases		274,722	2,299,468			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/25/2012 8:42 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	416,867	0	0	0	0	1.00
2.00	Land Improvements	588,545	638,504	0	638,504	0	2.00
3.00	Buildings and Fixtures	14,928,180	1,085,075	0	1,085,075	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,014,543	578,529	0	578,529	0	5.00
6.00	Movable Equipment	8,422,328	1,424,394	0	1,424,394	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,370,463	3,726,502	0	3,726,502	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,370,463	3,726,502	0	3,726,502	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	NEW CAP REL COSTS-BLDG & FIXT	510,702	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	664,812	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,175,514	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	NEW 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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/25/2012 8:42 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	416,867	0				1.00
2.00	Land Improvements	1,227,049	0				2.00
3.00	Buildings and Fixtures	16,013,255	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	3,593,072	0				5.00
6.00	Movable Equipment	9,846,722	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	31,096,965	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	31,096,965	0				10.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	510,702				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	664,812				2.00
3.00	Total (sum of lines 1-2)	0	1,175,514				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	510,702	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,227,957	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,738,659	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/25/2012 8:42 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	510,702	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,227,957	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,738,659	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-85,556	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-10,742	ADMINISTRATIVE & GENERAL	5.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		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	-2,694,680			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	2,049			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-88,566	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	B	-5,928	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	16.00
17.00	Sale of drugs to other than patients	B	-313	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00	Sale of medical records and abstracts	B	-11,494	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0		0.00	32.00
33.00	DIETARY	B	-21,756	DIETARY	10.00	33.00
35.00	MISCELLANEOUS	B	-90,932	ADMINISTRATIVE & GENERAL	5.00	35.00
36.00	PHYSICIAN RECRUITMENT	A	-123,403	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	PUBLIC RELATIONS	A	-225,558	EMPLOYEE BENEFITS	4.00	37.00
39.00	CRNA SALARY	A	-806,245	NONPHYSICIAN ANESTHETISTS	19.00	39.00
40.00	CRNA EMP BEN	A	-302,949	EMPLOYEE BENEFITS	4.00	40.00
42.00	EMPLOYEE DISCOUNT	A	106,473	EMPLOYEE BENEFITS	4.00	42.00
43.00	ORTHO EMP BEN	A	-324,592	EMPLOYEE BENEFITS	4.00	43.00
44.00	SURGEONS EMP BEN	A	-235,853	EMPLOYEE BENEFITS	4.00	44.00
45.00			0		0.00	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,920,045			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	9		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 - NEW CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	DIETARY	0		33.00
35.00	MISCELLANEOUS	0		35.00
36.00	PHYSICIAN RECRUITMENT	0		36.00
37.00	PUBLIC RELATIONS	0		37.00
39.00	CRNA SALARY	0		39.00
40.00	CRNA EMP BEN	0		40.00
42.00	EMPLOYEE DISCOUNT	0		42.00
43.00	ORTHO EMP BEN	0		43.00
44.00	SURGEONS EMP BEN	0		44.00
45.00		0		45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2012 8:42 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	1.00
2.00		0.00			2.00
3.00		0.00			3.00
4.00		0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

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

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

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

6.00		A	DSS MRI	100.00		6.00
7.00				0.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2012 8:42 am

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		217,142	215,093	2,049	0		1.00
2.00		0	0	0	0		2.00
3.00		0	0	0	0		3.00
4.00		0	0	0	0		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	217,142	215,093	2,049			5.00

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

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2012 8:42 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		54.00	RADIOLOGY-DIAGNOSTIC	16,219	16,219	1.00
2.00		60.00	LABORATORY	6,977	6,977	2.00
3.00		65.00	RESPIRATORY THERAPY	107,830	107,830	3.00
4.00		90.00	CLINIC	120,800	120,800	4.00
5.00		90.01	ORTHOPAEDIC CLINIC	863,843	863,843	5.00
6.00		90.02	SURGICAL CLINIC	627,680	627,680	6.00
7.00		91.00	EMERGENCY	1,389,519	951,331	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				3,132,868	2,694,680	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2012 8:42 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		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		438,188	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		438,188		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2012 8:42 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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2012 8:42 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	16,219		1.00
2.00		0	6,977		2.00
3.00		0	107,830		3.00
4.00		0	120,800		4.00
5.00		0	863,843		5.00
6.00		0	627,680		6.00
7.00		0	951,331		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	2,694,680		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	510,702	510,702				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,227,957		1,227,957			2.00
4.00	EMPLOYEE BENEFITS	3,953,267	1,224	2,943	3,957,434		4.00
5.00	ADMINISTRATIVE & GENERAL	3,012,497	36,969	88,889	430,547	3,568,902	5.00
7.00	OPERATION OF PLANT	810,723	21,931	52,733	62,942	948,329	7.00
9.00	HOUSEKEEPING	272,271	5,491	13,204	94,341	385,307	9.00
10.00	DIETARY	146,065	34,886	83,882	40,754	305,587	10.00
11.00	CAFETERIA	282,141	0	0	95,393	377,534	11.00
13.00	NURSING ADMINISTRATION	189,205	2,635	6,336	75,385	273,561	13.00
16.00	MEDICAL RECORDS & LIBRARY	327,410	9,912	23,832	121,338	482,492	16.00
17.00	SOCIAL SERVICE	137,520	3,273	7,869	53,200	201,862	17.00
19.00	NONPHYSICIAN ANESTHETISTS	18,563	0	0	0	18,563	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,482,273	85,812	206,333	498,458	2,272,876	30.00
31.00	INTENSIVE CARE UNIT	256,480	21,506	51,711	108,257	437,954	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	896,200	59,317	142,624	266,566	1,364,707	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,370,341	41,550	99,906	248,846	1,760,643	54.00
60.00	LABORATORY	1,180,252	8,569	20,603	269,780	1,479,204	60.00
65.00	RESPIRATORY THERAPY	446,629	9,436	22,687	171,934	650,686	65.00
66.00	PHYSICAL THERAPY	535,454	38,354	92,221	213,702	879,731	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	812,832	11,272	27,102	19,233	870,439	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,210,192	0	0	0	1,210,192	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,360,767	4,301	10,342	134,909	1,510,319	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	184,630	8,509	20,459	76,447	290,045	88.00
90.00	CLINIC	172,439	11,348	27,286	65,575	276,648	90.00
90.01	ORTHOPAEDIC CLINIC	400,948	30,602	73,581	104,915	610,046	90.01
90.02	SURGICAL CLINIC	286,884	0	0	65,599	352,483	90.02
90.03	OP CLINIC	16,197	0	0	6,371	22,568	90.03
91.00	EMERGENCY	1,399,735	27,907	67,101	393,301	1,888,044	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	504,685	30,330	72,926	186,764	794,705	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,405,259	505,134	1,214,570	3,804,557	23,233,427	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,176	5,232	0	7,408	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	840,608	3,392	8,155	152,877	1,005,032	192.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	24,245,867	510,702	1,227,957	3,957,434	24,245,867	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	3,568,902					5.00
7.00	OPERATION OF PLANT	163,684	1,112,013				7.00
9.00	HOUSEKEEPING	66,505	13,552	465,364			9.00
10.00	DIETARY	52,745	86,098	7,883	452,313		10.00
11.00	CAFETERIA	65,164	0	0	0	442,698	11.00
13.00	NURSING ADMINISTRATION	47,217	6,503	0	0	5,613	13.00
16.00	MEDICAL RECORDS & LIBRARY	83,280	24,462	0	0	25,556	16.00
17.00	SOCIAL SERVICE	34,842	8,077	0	0	6,961	17.00
19.00	NONPHYSICIAN ANESTHETISTS	3,204	0	0	0	8,780	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	392,301	211,784	242,212	440,438	78,426	30.00
31.00	INTENSIVE CARE UNIT	75,592	53,077	0	11,875	12,292	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	235,553	146,391	66,898	0	32,893	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	303,892	102,545	35,284	0	31,671	54.00
60.00	LABORATORY	255,315	21,147	1,814	0	34,900	60.00
65.00	RESPIRATORY THERAPY	112,310	23,287	3,065	0	22,263	65.00
66.00	PHYSICAL THERAPY	151,844	94,657	26,692	0	22,326	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	150,240	27,818	0	0	3,230	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	208,883	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	260,686	10,615	0	0	13,578	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	50,063	21,000	0	0	6,804	88.00
90.00	CLINIC	47,750	28,007	438	0	9,752	90.00
90.01	ORTHOPAEDIC CLINIC	105,296	75,524	0	0	27,155	90.01
90.02	SURGICAL CLINIC	60,840	0	0	0	16,525	90.02
90.03	OP CLINIC	3,895	0	0	0	972	90.03
91.00	EMERGENCY	325,882	68,874	81,078	0	46,596	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	137,168	74,853	0	0	36,405	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,394,151	1,098,271	465,364	452,313	442,698	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,279	5,371	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	173,472	8,371	0	0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,568,902	1,112,013	465,364	452,313	442,698	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		13.00	16.00	17.00	19.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	332,894					13.00
16.00	MEDICAL RECORDS & LIBRARY	0	615,790				16.00
17.00	SOCIAL SERVICE	0	0	251,742			17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	30,547		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	153,384	535,798	245,463	0	4,572,682	30.00
31.00	INTENSIVE CARE UNIT	24,041	35,901	6,279	0	657,011	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	64,334	0	0	0	1,910,776	50.00
53.00	ANESTHESIOLOGY	0	0	0	30,547	30,547	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	2,234,035	54.00
60.00	LABORATORY	0	0	0	0	1,792,380	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	811,611	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	1,175,250	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,051,727	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,419,075	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,795,198	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	367,912	88.00
90.00	CLINIC	0	0	0	0	362,595	90.00
90.01	ORTHOPAEDIC CLINIC	0	0	0	0	818,021	90.01
90.02	SURGICAL CLINIC	0	0	0	0	429,848	90.02
90.03	OP CLINIC	0	0	0	0	27,435	90.03
91.00	EMERGENCY	91,135	44,091	0	0	2,545,700	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	1,043,131	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	332,894	615,790	251,742	30,547	23,044,934	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	14,058	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,186,875	192.00
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	332,894	615,790	251,742	30,547	24,245,867	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
7.00	OPERATION OF PLANT				7.00
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
19.00	NONPHYSICIAN ANESTHETISTS				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	4,572,682		30.00
31.00	INTENSIVE CARE UNIT	0	657,011		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,910,776		50.00
53.00	ANESTHESIOLOGY	0	30,547		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,234,035		54.00
60.00	LABORATORY	0	1,792,380		60.00
65.00	RESPIRATORY THERAPY	0	811,611		65.00
66.00	PHYSICAL THERAPY	0	1,175,250		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,051,727		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,419,075		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,795,198		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	367,912		88.00
90.00	CLINIC	0	362,595		90.00
90.01	ORTHOPAEDIC CLINIC	0	818,021		90.01
90.02	SURGICAL CLINIC	0	429,848		90.02
90.03	OP CLINIC	0	27,435		90.03
91.00	EMERGENCY	0	2,545,700		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	1,043,131		95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	23,044,934		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,058		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,186,875		192.00
200.00	Cross Foot Adjustments	0	0		200.00
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	24,245,867		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	1,224	2,943	4,167	4,167	4.00
5.00	ADMINISTRATIVE & GENERAL	0	36,969	88,889	125,858	454	5.00
7.00	OPERATION OF PLANT	0	21,931	52,733	74,664	66	7.00
9.00	HOUSEKEEPING	0	5,491	13,204	18,695	99	9.00
10.00	DIETARY	0	34,886	83,882	118,768	43	10.00
11.00	CAFETERIA	0	0	0	0	101	11.00
13.00	NURSING ADMINISTRATION	0	2,635	6,336	8,971	79	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	9,912	23,832	33,744	128	16.00
17.00	SOCIAL SERVICE	0	3,273	7,869	11,142	56	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	85,812	206,333	292,145	522	30.00
31.00	INTENSIVE CARE UNIT	0	21,506	51,711	73,217	114	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	59,317	142,624	201,941	281	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	41,550	99,906	141,456	262	54.00
60.00	LABORATORY	0	8,569	20,603	29,172	284	60.00
65.00	RESPIRATORY THERAPY	0	9,436	22,687	32,123	181	65.00
66.00	PHYSICAL THERAPY	0	38,354	92,221	130,575	225	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,272	27,102	38,374	20	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,301	10,342	14,643	142	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	8,509	20,459	28,968	81	88.00
90.00	CLINIC	0	11,348	27,286	38,634	69	90.00
90.01	ORTHOPAEDIC CLINIC	0	30,602	73,581	104,183	111	90.01
90.02	SURGICAL CLINIC	0	0	0	0	69	90.02
90.03	OP CLINIC	0	0	0	0	7	90.03
91.00	EMERGENCY	0	27,907	67,101	95,008	415	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	30,330	72,926	103,256	197	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	505,134	1,214,570	1,719,704	4,006	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,176	5,232	7,408	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,392	8,155	11,547	161	192.00
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	510,702	1,227,957	1,738,659	4,167	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	126,312					5.00
7.00	OPERATION OF PLANT	5,793	80,523				7.00
9.00	HOUSEKEEPING	2,354	981	22,129			9.00
10.00	DIETARY	1,867	6,235	375	127,288		10.00
11.00	CAFETERIA	2,306	0	0	0	2,407	11.00
13.00	NURSING ADMINISTRATION	1,671	471	0	0	31	13.00
16.00	MEDICAL RECORDS & LIBRARY	2,948	1,771	0	0	139	16.00
17.00	SOCIAL SERVICE	1,233	585	0	0	38	17.00
19.00	NONPHYSICIAN ANESTHETISTS	113	0	0	0	48	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	13,882	15,337	11,518	123,946	425	30.00
31.00	INTENSIVE CARE UNIT	2,675	3,843	0	3,342	67	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,337	10,600	3,181	0	179	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	10,756	7,426	1,678	0	172	54.00
60.00	LABORATORY	9,036	1,531	86	0	190	60.00
65.00	RESPIRATORY THERAPY	3,975	1,686	146	0	121	65.00
66.00	PHYSICAL THERAPY	5,374	6,854	1,269	0	121	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,318	2,014	0	0	18	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	7,393	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	9,227	769	0	0	74	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,772	1,521	0	0	37	88.00
90.00	CLINIC	1,690	2,028	21	0	53	90.00
90.01	ORTHOPAEDIC CLINIC	3,727	5,469	0	0	148	90.01
90.02	SURGICAL CLINIC	2,153	0	0	0	90	90.02
90.03	OP CLINIC	138	0	0	0	5	90.03
91.00	EMERGENCY	11,534	4,987	3,855	0	253	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	4,855	5,420	0	0	198	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	120,127	79,528	22,129	127,288	2,407	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45	389	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	6,140	606	0	0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	126,312	80,523	22,129	127,288	2,407	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		13.00	16.00	17.00	19.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	11,223					13.00
16.00	MEDICAL RECORDS & LIBRARY	0	38,730				16.00
17.00	SOCIAL SERVICE	0	0	13,054			17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	161		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,171	33,699	12,728		509,373	30.00
31.00	INTENSIVE CARE UNIT	811	2,258	326		86,653	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,169	0	0		226,688	50.00
53.00	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		161,750	54.00
60.00	LABORATORY	0	0	0		40,299	60.00
65.00	RESPIRATORY THERAPY	0	0	0		38,232	65.00
66.00	PHYSICAL THERAPY	0	0	0		144,418	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		45,744	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		7,393	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		24,855	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0		32,379	88.00
90.00	CLINIC	0	0	0		42,495	90.00
90.01	ORTHOPAEDIC CLINIC	0	0	0		113,638	90.01
90.02	SURGICAL CLINIC	0	0	0		2,312	90.02
90.03	OP CLINIC	0	0	0		150	90.03
91.00	EMERGENCY	3,072	2,773	0		121,897	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0		113,926	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,223	38,730	13,054	0	1,712,202	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		7,842	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0		18,454	192.00
200.00	Cross Foot Adjustments				161	161	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	11,223	38,730	13,054	161	1,738,659	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
7.00	OPERATION OF PLANT				7.00
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
19.00	NONPHYSICIAN ANESTHETISTS				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	509,373		30.00
31.00	INTENSIVE CARE UNIT	0	86,653		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	226,688		50.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	161,750		54.00
60.00	LABORATORY	0	40,299		60.00
65.00	RESPIRATORY THERAPY	0	38,232		65.00
66.00	PHYSICAL THERAPY	0	144,418		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,744		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	7,393		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	24,855		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	32,379		88.00
90.00	CLINIC	0	42,495		90.00
90.01	ORTHOPAEDIC CLINIC	0	113,638		90.01
90.02	SURGICAL CLINIC	0	2,312		90.02
90.03	OP CLINIC	0	150		90.03
91.00	EMERGENCY	0	121,897		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	113,926		95.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,712,202		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,842		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	18,454		192.00
200.00	Cross Foot Adjustments	0	161		200.00
201.00	Negative Cost Centers	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	1,738,659		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	60,079					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		60,079				2.00
4.00	EMPLOYEE BENEFITS	144	144	9,290,417			4.00
5.00	ADMINISTRATIVE & GENERAL	4,349	4,349	1,010,747	-3,568,902	20,676,965	5.00
7.00	OPERATION OF PLANT	2,580	2,580	147,763	0	948,329	7.00
9.00	HOUSEKEEPING	646	646	221,475	0	385,307	9.00
10.00	DIETARY	4,104	4,104	95,673	0	305,587	10.00
11.00	CAFETERIA	0	0	223,943	0	377,534	11.00
13.00	NURSING ADMINISTRATION	310	310	176,972	0	273,561	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,166	1,166	284,852	0	482,492	16.00
17.00	SOCIAL SERVICE	385	385	124,892	0	201,862	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	18,563	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	10,095	10,095	1,170,163	0	2,272,876	30.00
31.00	INTENSIVE CARE UNIT	2,530	2,530	254,144	0	437,954	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,978	6,978	625,788	0	1,364,707	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,888	4,888	584,188	0	1,760,643	54.00
60.00	LABORATORY	1,008	1,008	633,333	0	1,479,204	60.00
65.00	RESPIRATORY THERAPY	1,110	1,110	403,630	0	650,686	65.00
66.00	PHYSICAL THERAPY	4,512	4,512	501,684	0	879,731	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,326	1,326	45,151	0	870,439	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,210,192	72.00
73.00	DRUGS CHARGED TO PATIENTS	506	506	316,712	0	1,510,319	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,001	1,001	179,467	0	290,045	88.00
90.00	CLINIC	1,335	1,335	153,942	0	276,648	90.00
90.01	ORTHOPAEDIC CLINIC	3,600	3,600	246,297	0	610,046	90.01
90.02	SURGICAL CLINIC	0	0	154,000	0	352,483	90.02
90.03	OP CLINIC	0	0	14,956	0	22,568	90.03
91.00	EMERGENCY	3,283	3,283	923,309	0	1,888,044	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	3,568	3,568	438,444	0	794,705	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	59,424	59,424	8,931,525	-3,568,902	19,664,525	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	256	256	0	0	7,408	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	399	399	358,892	0	1,005,032	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	510,702	1,227,957	3,957,434		3,568,902	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.500508	20.439039	0.425969		0.172603	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			4,167		126,312	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000449		0.006109	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (POUNDS)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (NURSE FTE'S)	
		7.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	53,006					7.00
9.00	HOUSEKEEPING	646	22,316				9.00
10.00	DIETARY	4,104	378	8,913			10.00
11.00	CAFETERIA	0	0	0	14,118		11.00
13.00	NURSING ADMINISTRATION	310	0	0	179	5,428	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,166	0	0	815	0	16.00
17.00	SOCIAL SERVICE	385	0	0	222	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	280	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	10,095	11,615	8,679	2,501	2,501	30.00
31.00	INTENSIVE CARE UNIT	2,530	0	234	392	392	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,978	3,208	0	1,049	1,049	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,888	1,692	0	1,010	0	54.00
60.00	LABORATORY	1,008	87	0	1,113	0	60.00
65.00	RESPIRATORY THERAPY	1,110	147	0	710	0	65.00
66.00	PHYSICAL THERAPY	4,512	1,280	0	712	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,326	0	0	103	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	506	0	0	433	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,001	0	0	217	0	88.00
90.00	CLINIC	1,335	21	0	311	0	90.00
90.01	ORTHOPAEDIC CLINIC	3,600	0	0	866	0	90.01
90.02	SURGICAL CLINIC	0	0	0	527	0	90.02
90.03	OP CLINIC	0	0	0	31	0	90.03
91.00	EMERGENCY	3,283	3,888	0	1,486	1,486	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	3,568	0	0	1,161	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	52,351	22,316	8,913	14,118	5,428	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	256	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	399	0	0	0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,112,013	465,364	452,313	442,698	332,894	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20.979002	20.853379	50.747560	31.356991	61.329035	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	80,523	22,129	127,288	2,407	11,223	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.519130	0.991620	14.281162	0.170492	2.067612	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		16.00	17.00	19.00		
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
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	10,000				16.00
17.00	SOCIAL SERVICE	0	2,967			17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	100		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	8,701	2,893			30.00
31.00	INTENSIVE CARE UNIT	583	74			31.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
53.00	ANESTHESIOLOGY	0	0	100		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	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	CLINIC	0	0	0		90.00
90.01	ORTHOPAEDIC CLINIC	0	0	0		90.01
90.02	SURGICAL CLINIC	0	0	0		90.02
90.03	OP CLINIC	0	0	0		90.03
91.00	EMERGENCY	716	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0	0	0		95.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,000	2,967	100		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	615,790	251,742	30,547		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	61.579000	84.847321	305.470000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	38,730	13,054	161		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.873000	4.399730	1.610000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/25/2012 8:42 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	4,572,682		4,572,682	0	0	30.00
31.00	INTENSIVE CARE UNIT	657,011		657,011	0	0	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,910,776		1,910,776	0	0	50.00
53.00	ANESTHESIOLOGY	30,547		30,547	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,234,035		2,234,035	0	0	54.00
60.00	LABORATORY	1,792,380		1,792,380	0	0	60.00
65.00	RESPIRATORY THERAPY	811,611	0	811,611	0	0	65.00
66.00	PHYSICAL THERAPY	1,175,250	0	1,175,250	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,051,727		1,051,727	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,419,075		1,419,075	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,795,198		1,795,198	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	367,912		367,912	0	0	88.00
90.00	CLINIC	362,595		362,595	0	0	90.00
90.01	ORTHOPAEDIC CLINIC	818,021		818,021	0	0	90.01
90.02	SURGICAL CLINIC	429,848		429,848	0	0	90.02
90.03	OP CLINIC	27,435		27,435	0	0	90.03
91.00	EMERGENCY	2,545,700		2,545,700	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	742,439		742,439		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	1,043,131		1,043,131	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	23,787,373	0	23,787,373	0	0	200.00
201.00	Less Observation Beds	742,439		742,439		0	201.00
202.00	Total (see instructions)	23,044,934	0	23,044,934	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/25/2012 8:42 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	3,073,168		3,073,168			30.00
31.00	INTENSIVE CARE UNIT	90,630		90,630			31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,758,211	5,016,503	7,774,714	0.245768	0.000000	50.00
53.00	ANESTHESIOLOGY	632,404	1,141,192	1,773,596	0.017223	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	638,587	10,100,960	10,739,547	0.208019	0.000000	54.00
60.00	LABORATORY	941,353	8,285,433	9,226,786	0.194258	0.000000	60.00
65.00	RESPIRATORY THERAPY	390,413	1,145,055	1,535,468	0.528576	0.000000	65.00
66.00	PHYSICAL THERAPY	317,449	1,189,856	1,507,305	0.779703	0.000000	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,064,859	943,215	2,008,074	0.523749	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	2,157,075	355,697	2,512,772	0.564745	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,622,984	2,709,548	4,332,532	0.414353	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	440,240	440,240			88.00
90.00	CLINIC	0	17,189	17,189	21.094595	0.000000	90.00
90.01	ORTHOPAEDIC CLINIC	0	202,066	202,066	4.048286	0.000000	90.01
90.02	SURGICAL CLINIC	0	50,518	50,518	8.508809	0.000000	90.02
90.03	OP CLINIC	0	64,485	64,485	0.425448	0.000000	90.03
91.00	EMERGENCY	62,899	4,074,713	4,137,612	0.615258	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	6,500	383,128	389,628	1.905507	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	836	1,444,242	1,445,078	0.721851	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	13,757,368	37,564,040	51,321,408			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	13,757,368	37,564,040	51,321,408			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/25/2012 8:42 am

Title XVIII | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
	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	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC			88.00
90.00	CLINIC	0.000000		90.00
90.01	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	SURGICAL CLINIC	0.000000		90.02
90.03	OP CLINIC	0.000000		90.03
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	0.000000		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part II Date/Time Prepared: 5/25/2012 8:42 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	226,688	7,774,714	0.029157	1,540,724	44,923	50.00
53.00	ANESTHESIOLOGY	0	1,773,596	0.000000	145,765	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	161,750	10,739,547	0.015061	381,849	5,751	54.00
60.00	LABORATORY	40,299	9,226,786	0.004368	705,947	3,084	60.00
65.00	RESPIRATORY THERAPY	38,232	1,535,468	0.024899	319,327	7,951	65.00
66.00	PHYSICAL THERAPY	144,418	1,507,305	0.095812	177,953	17,050	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,744	2,008,074	0.022780	666,279	15,178	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	7,393	2,512,772	0.002942	1,360,284	4,002	72.00
73.00	DRUGS CHARGED TO PATIENTS	24,855	4,332,532	0.005737	1,053,683	6,045	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	32,379	440,240	0.073549	0	0	88.00
90.00	CLINIC	42,495	17,189	2.472221	0	0	90.00
90.01	ORTHOPAEDIC CLINIC	113,638	202,066	0.562381	0	0	90.01
90.02	SURGICAL CLINIC	2,312	50,518	0.045766	0	0	90.02
90.03	OP CLINIC	150	64,485	0.002326	0	0	90.03
91.00	EMERGENCY	121,897	4,137,612	0.029461	2,155	63	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	389,628	0.000000	1,254	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,002,250	46,712,532		6,355,220	104,047	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/25/2012 8:42 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	30,547	0	0	0	30,547	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	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	OP CLINIC	0	0	0	0	0	90.03
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	30,547	0	0	0	30,547	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/25/2012 8:42 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	7,774,714	0.000000	0.000000	1,540,724	50.00
53.00	ANESTHESIOLOGY	0	1,773,596	0.017223	0.000000	145,765	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	10,739,547	0.000000	0.000000	381,849	54.00
60.00	LABORATORY	0	9,226,786	0.000000	0.000000	705,947	60.00
65.00	RESPIRATORY THERAPY	0	1,535,468	0.000000	0.000000	319,327	65.00
66.00	PHYSICAL THERAPY	0	1,507,305	0.000000	0.000000	177,953	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,008,074	0.000000	0.000000	666,279	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	2,512,772	0.000000	0.000000	1,360,284	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,332,532	0.000000	0.000000	1,053,683	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	440,240	0.000000	0.000000	0	88.00
90.00	CLINIC	0	17,189	0.000000	0.000000	0	90.00
90.01	ORTHOPAEDIC CLINIC	0	202,066	0.000000	0.000000	0	90.01
90.02	SURGICAL CLINIC	0	50,518	0.000000	0.000000	0	90.02
90.03	OP CLINIC	0	64,485	0.000000	0.000000	0	90.03
91.00	EMERGENCY	0	4,137,612	0.000000	0.000000	2,155	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	389,628	0.000000	0.000000	1,254	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	46,712,532			6,355,220	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/25/2012 8:42 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	2,511	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	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	CLINIC	0	0	0		90.00
90.01	ORTHOPAEDIC CLINIC	0	0	0		90.01
90.02	SURGICAL CLINIC	0	0	0		90.02
90.03	OP CLINIC	0	0	0		90.03
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	2,511	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/25/2012 8:42 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	0.245768	0	1,451,806	0		50.00
53.00	ANESTHESIOLOGY	0.017223	0	158,824	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.208019	0	3,976,984	0		54.00
60.00	LABORATORY	0.194258	0	4,181,875	0		60.00
65.00	RESPIRATORY THERAPY	0.528576	0	526,516	0		65.00
66.00	PHYSICAL THERAPY	0.779703	0	447,528	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.523749	0	283,079	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.564745	0	82,856	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.414353	0	1,800,477	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
90.00	CLINIC	21.094595	0	10,513	0		90.00
90.01	ORTHOPAEDIC CLINIC	4.048286	0	60,857	0		90.01
90.02	SURGICAL CLINIC	8.508809	0	21,629	0		90.02
90.03	OP CLINIC	0.425448	0	0	0		90.03
91.00	EMERGENCY	0.615258	0	1,290,694	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.905507	0	372,952	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.721851		0			95.00
200.00	Subtotal (see instructions)		0	14,666,590	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	14,666,590	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/25/2012 8:42 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	356,807	0		50.00
53.00	ANESTHESIOLOGY	0	2,735	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	827,288	0		54.00
60.00	LABORATORY	0	812,363	0		60.00
65.00	RESPIRATORY THERAPY	0	278,304	0		65.00
66.00	PHYSICAL THERAPY	0	348,939	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	148,262	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	46,793	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	746,033	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	CLINIC	0	221,767	0		90.00
90.01	ORTHOPAEDIC CLINIC	0	246,367	0		90.01
90.02	SURGICAL CLINIC	0	184,037	0		90.02
90.03	OP CLINIC	0	0	0		90.03
91.00	EMERGENCY	0	794,110	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	710,663	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	5,724,468	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	5,724,468	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V | Date/Time Prepared: 5/25/2012 8:42 am

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	0.245768	0	0	0		50.00
53.00	ANESTHESIOLOGY	0.017223	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.208019	0	0	0		54.00
60.00	LABORATORY	0.194258	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0.528576	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.779703	0	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.523749	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.564745	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.414353	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
90.00	CLINIC	21.094595	0	0	0		90.00
90.01	ORTHOPAEDIC CLINIC	4.048286	0	0	0		90.01
90.02	SURGICAL CLINIC	8.508809	0	0	0		90.02
90.03	OP CLINIC	0.425448	0	0	0		90.03
91.00	EMERGENCY	0.615258	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.905507	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.721851		0			95.00
200.00	Subtotal (see instructions)		0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V | Date/Time Prepared: 5/25/2012 8:42 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	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	CLINIC	0	0	0		90.00
90.01	ORTHOPAEDIC CLINIC	0	0	0		90.01
90.02	SURGICAL CLINIC	0	0	0		90.02
90.03	OP CLINIC	0	0	0		90.03
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/25/2012 8:42 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	785,794		50.00
53.00	ANESTHESIOLOGY	0.000000	0	0	235,667		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	1,667,917		54.00
60.00	LABORATORY	0.000000	0	0	950,753		60.00
65.00	RESPIRATORY THERAPY	0.000000	0	0	184,149		65.00
66.00	PHYSICAL THERAPY	0.000000	0	0	144,400		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	201,209		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	0	0	295,748		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
90.00	CLINIC	0.000000	0	0	68,183		90.00
90.01	ORTHOPAEDIC CLINIC	0.000000	0	0	0		90.01
90.02	SURGICAL CLINIC	0.000000	0	0	0		90.02
90.03	OP CLINIC	0.000000	0	0	19,849		90.03
91.00	EMERGENCY	0.000000	0	0	1,006,885		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00	Subtotal (see instructions)		0	0	5,560,554		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	5,560,554		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/25/2012 8:42 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	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	CLINIC	0	0	0		90.00
90.01	ORTHOPAEDIC CLINIC	0	0	0		90.01
90.02	SURGICAL CLINIC	0	0	0		90.02
90.03	OP CLINIC	0	0	0		90.03
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/25/2012 8:42 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)	3,444	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,061	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)	3,061	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	329	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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)	1,953	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)	329	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	90.06	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	90.06	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,572,682	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)	4,863	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)	448,171	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,124,511	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,462,796	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,462,796	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.191093	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)	1,131.26	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)	4,124,511	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)	1,347.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,631,550	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)	2,631,550	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/25/2012 8:42 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	657,011	74	8,878.53	40	355,141	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)	2,462,769	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,449,460	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)	443,308	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	443,308	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)	551	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,347.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	742,439	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/25/2012 8:42 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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141327	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/25/2012 8:42 am
	Title XIX	Hospital	

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,444	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,061	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)	3,061	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	329	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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)	112	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	54	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	90.06	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	90.06	20.00
21.00	Total general inpatient routine service cost (see instructions)	0	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)	4,863	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)	4,393	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	-4,393	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,462,796	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,462,796	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	-0.001269	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)	1,131.26	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)	-4,393	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)	-1.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	-160	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)	-160	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/25/2012 8:42 am

Title XIX | Hospital

	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	0	74	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description	1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	-160	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)	-160	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	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)	4,863	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)	4,863	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)	551	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	-1.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	-793	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/25/2012 8:42 am

Title XIX | Hospital

	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	-4,393	0.000000	-793	0	90.00
91.00	Nursing School cost	0	-4,393	0.000000	-793	0	91.00
92.00	Allied health cost	0	-4,393	0.000000	-793	0	92.00
93.00	All other Medical Education	0	-4,393	0.000000	-793	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/25/2012 8:42 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		1,994,978		30.00
31.00	INTENSIVE CARE UNIT		65,415		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.245768	1,540,724	378,661	50.00
53.00	ANESTHESIOLOGY	0.017223	145,765	2,511	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.208019	381,849	79,432	54.00
60.00	LABORATORY	0.194258	705,947	137,136	60.00
65.00	RESPIRATORY THERAPY	0.528576	319,327	168,789	65.00
66.00	PHYSICAL THERAPY	0.779703	177,953	138,750	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.523749	666,279	348,963	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.564745	1,360,284	768,214	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.414353	1,053,683	436,597	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	CLINIC	21.094595	0	0	90.00
90.01	ORTHOPAEDIC CLINIC	4.048286	0	0	90.01
90.02	SURGICAL CLINIC	8.508809	0	0	90.02
90.03	OP CLINIC	0.425448	0	0	90.03
91.00	EMERGENCY	0.615258	2,155	1,326	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.905507	1,254	2,390	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		6,355,220	2,462,769	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)		6,355,220		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/25/2012 8:42 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
31.00	INTENSIVE CARE UNIT		0		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.245768	0	0	50.00
53.00	ANESTHESIOLOGY	0.017223	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.208019	25,768	5,360	54.00
60.00	LABORATORY	0.194258	40,487	7,865	60.00
65.00	RESPIRATORY THERAPY	0.528576	44,541	23,543	65.00
66.00	PHYSICAL THERAPY	0.779703	68,036	53,048	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.523749	51,238	26,836	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.564745	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.414353	152,409	63,151	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	CLINIC	21.094595	0	0	90.00
90.01	ORTHOPAEDIC CLINIC	4.048286	0	0	90.01
90.02	SURGICAL CLINIC	8.508809	0	0	90.02
90.03	OP CLINIC	0.425448	0	0	90.03
91.00	EMERGENCY	0.615258	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.905507	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		382,479	179,803	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)		382,479		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/25/2012 8:42 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		177,581		30.00
31.00	INTENSIVE CARE UNIT		8,450		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000	189,117	0	50.00
53.00	ANESTHESIOLOGY	0.000000	52,217	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	49,770	0	54.00
60.00	LABORATORY	0.000000	44,087	0	60.00
65.00	RESPIRATORY THERAPY	0.000000	20,839	0	65.00
66.00	PHYSICAL THERAPY	0.000000	7,969	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	150,351	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	82,328	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	CLINIC	0.000000	0	0	90.00
90.01	ORTHOPAEDIC CLINIC	0.000000	0	0	90.01
90.02	SURGICAL CLINIC	0.000000	0	0	90.02
90.03	OP CLINIC	0.000000	0	0	90.03
91.00	EMERGENCY	0.000000	3,419	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		600,097	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)		600,097		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141327	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/25/2012 8:42 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,724,468	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)	5,724,468	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)	5,781,713	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)	56,564	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,105,957	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)	3,619,192	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)	3,619,192	30.00
31.00	Primary payer payments	376	31.00
32.00	Subtotal (line 30 minus line 31)	3,618,816	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)	203,175	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	203,175	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	3,821,991	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	3,821,991	40.00
41.00	Interim payments	3,461,537	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)	360,454	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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2012 8:42 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		3,761,742		3,061,612	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		65,148		303,052	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/22/2011	180,766	08/22/2011	79,497	3.01
3.02		12/02/2011	148,683	12/02/2011	17,376	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)		329,449		96,873	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)		4,156,339		3,461,537	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		965,835		360,454	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,122,174		3,821,991	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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2012 8:42 am

Component CCN: 14Z327 | 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		508,113		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/22/2011	40,409		0	3.01
3.02		12/02/2011	9,885		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)		50,294		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)		558,407		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		66,973		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		625,380		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: 141327 Component CCN: 14Z327	Period: From 01/01/2011 To 12/31/2011	Worksheet E-2 Date/Time Prepared: 5/25/2012 8:42 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)	447,741	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)	181,601	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	329	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)	629,342	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	629,342	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)	629,342	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,962	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)	625,380	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)	625,380	0	19.00
20.00	Interim payments	558,407	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)	66,973	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: 141327	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/25/2012 8:42 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	5,449,460	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)	5,449,460	4.00
5.00	Primary payer payments	4,842	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)	5,499,113	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)	5,499,113	19.00
20.00	Deductibles (exclude professional component)	416,475	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	5,082,638	22.00
23.00	Coinsurance	7,641	23.00
24.00	Subtotal (line 22 minus line 23)	5,074,997	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,177	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	47,177	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)	5,122,174	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)	5,122,174	30.00
31.00	Interim payments	4,156,339	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)	965,835	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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G | Date/Time Prepared: 5/25/2012 8:42 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	2,125,892	0	0	0	1.00
2.00	Temporary investments	2,349,371	0	0	0	2.00
3.00	Notes receivable	69,308	0	0	0	3.00
4.00	Accounts receivable	13,175,443	0	0	0	4.00
5.00	Other receivable	86,993	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,259,616	0	0	0	6.00
7.00	Inventory	509,805	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	552,598	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)	12,609,794	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	31,096,965	0	0	0	15.00
16.00	Accumulated depreciation	-17,020,679	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)	14,076,286	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	329,040	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	329,040	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	27,015,120	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	732,589	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,404,049	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	118,942	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	749,699	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,005,279	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,655,000	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	8,655,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	12,660,279	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	14,354,841				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)	14,354,841	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,015,120	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/25/2012 8:42 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		12,978,473		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,599,593				2.00
3.00	Total (sum of line 1 and line 2)		14,578,066		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)		14,578,066		0		11.00
12.00	Deductions (debit adjustments) (specify)	223,225		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)		223,225		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,354,841		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/25/2012 8:42 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: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-2 Parts | Date/Time Prepared: 5/25/2012 8:42 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,462,796		3,462,796	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)	3,462,796		3,462,796	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	90,630		90,630	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)	90,630		90,630	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,553,426		3,553,426	17.00
18.00	Ancillary services	10,799,733	35,364,376	46,164,109	18.00
19.00	Outpatient services	0	570,973	570,973	19.00
20.00	RURAL HEALTH CLINIC	0	440,240	440,240	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	836	1,444,242	1,445,078	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	32,350	8,578,974	8,611,324	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,386,345	46,398,805	60,785,150	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		29,165,912		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	NON-OPERATING EXPENSES	3,152,165			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)		3,152,165		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,013,747		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141327	Period: From 01/01/2011 To 12/31/2011	Worksheet G-3 Date/Time Prepared: 5/25/2012 8:42 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	60,785,150	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,398,907	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,386,243	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,013,747	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,372,496	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,076,528	24.00
24.01	NON-OPERATING DEDUCTIONS	2,624,341	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	3,700,869	25.00
26.00	Total (line 5 plus line 25)	7,073,365	26.00
27.00	NON-OPERATING G/L	166,850	27.00
27.01	NON-OPERATING REVENUE	5,306,922	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	5,473,772	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,599,593	29.00

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

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2011 To 12/31/2011 | Worksheet M-1 | Date/Time Prepared: 5/25/2012 8:42 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	0	0	0	0	0	1.00
2.00	Physician Assistant	100,602	0	100,602	0	100,602	2.00
3.00	Nurse Practitioner	18,387	0	18,387	0	18,387	3.00
4.00	Visiting Nurse	688	0	688	0	688	4.00
5.00	Other Nurse	59,790	0	59,790	0	59,790	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)	179,467	0	179,467	0	179,467	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	3,795	3,795	0	3,795	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	3,795	3,795	0	3,795	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	179,467	3,795	183,262	0	183,262	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	3,211	3,211	-1,843	1,368	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	3,211	3,211	-1,843	1,368	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	179,467	7,006	186,473	-1,843	184,630	32.00

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

Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet M-1

Component CCN: 148501 | Date/Time Prepared: 5/25/2012 8:42 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	0		1.00
2.00	Physician Assistant	0	100,602		2.00
3.00	Nurse Practitioner	0	18,387		3.00
4.00	Visiting Nurse	0	688		4.00
5.00	Other Nurse	0	59,790		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	179,467		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	3,795		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	3,795		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	183,262		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	1,368		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,368		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	184,630		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141327 | Period: From 01/01/2011 To 12/31/2011 | Worksheet M-2

Component CCN: 148501 | Date/Time Prepared: 5/25/2012 8:42 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	0.10	11	4,200	420		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.05	5,252	2,100	2,205		3.00
4.00	Subtotal (sum of lines 1-3)	1.15	5,263		2,625	5,263	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.15	5,263			5,263	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)					183,262	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)					183,262	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)					1,368	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					183,282	15.00
16.00	Total overhead (sum of lines 14 and 15)					184,650	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					184,650	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					184,650	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					367,912	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2011 To 12/31/2011 | Worksheet M-3 | Date/Time Prepared: 5/25/2012 8:42 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)		367,912	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)		367,912	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,263	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)		5,263	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		69.91	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)	69.91	69.91	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	303	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	21,183	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	21,183	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		13,757	16.04
16.05	Total program cost (see instructions)		13,757	16.05
17.00	Primary payer amounts		179	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,987	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)		13,578	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)		13,578	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		13,578	26.00
27.00	Interim payments		13,298	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)		280	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: 141327 Component CCN: 148501	Period: From 01/01/2011 To 12/31/2011	Worksheet M-5 Date/Time Prepared: 5/25/2012 8:42 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		13,668	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		12/02/2011	370	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)		-370	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		13,298	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		280	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		13,578	7.00

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