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: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 12/19/2011 9:46 am

PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRISON COMMUNITY HOSPITAL for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	41,361	-14,874	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	166,864	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		24,408		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	208,225	9,534	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 12/19/2011 9:46 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 N. JACKSON	PO Box:			1.00
2.00	City: MORRISON	State: IL	Zip Code: 61270-	County: WHITESIDE	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	MORRISON COMMUNITY HOSPITAL	141329	14	1	08/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MORRISON SWING BED	14Z329	14		08/01/2003	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	MORRISON SNF	145274	14		08/13/1974	N	P	O	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	MORRISON COMMUNITY HOSPITAL CLINIC	143981	14		07/01/1996	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2010	06/30/2011	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/19/2011 9:46 am

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 12/19/2011 9:46 am

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 12/19/2011 9:46 am

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

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

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	1,000,000	3,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/19/2011 9:46 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	10,368.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	10,368.00		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	10,368.00		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	44.00	38	13,870			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10					25.10
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00	Total (sum of lines 14-26)		63				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: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 12/19/2011 9:46 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	234	21	432		1.00
2.00	HMO		15	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	1,803	0	1,862		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	205		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,037	21	2,499		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	2,037	21	2,499		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	0	0	6,376	10,504		19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0		25.10
26.00	RURAL HEALTH CLINIC	0	1,754	5,223	18,107		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		16	72		28.00
29.00	Ambulance Trips		188				29.00
30.00	Employee discount days (see instruction)				2		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: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 12/19/2011 9:46 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	74	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	101.30	0.00	0	74	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	0.00	22.46	0.00			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00	0.00	0.00			25.10
26.00	RURAL HEALTH CLINIC	0.00	10.51	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00	Total (sum of lines 14-26)	0.00	134.27	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: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 12/19/2011 9:46 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)	26	150		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)	26	150		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
25.10	CMHC - CORF				25.10
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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet S-7 Date/Time Prepared: 12/19/2011 9:46 am

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

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-7 | Date/Time Prepared: 12/19/2011 9:46 am

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

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,738,331			207.00

		1.00	
1.00	Wage Index Factor	0.0000	1.00

		Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate On/After 10/1	
		1.00	2.00	3.00	4.00	5.00	
3.00		RUX	195.01	195.01	0	269.98	3.00
4.00		RUL	174.43	174.43	0	263.50	4.00
5.00		RVX	146.09	146.09	0	241.45	5.00
6.00		RVL	137.14	137.14	0	215.54	6.00
7.00		RHX	122.05	122.05	0	219.66	7.00
8.00		RHL	119.37	119.37	0	194.67	8.00
9.00		RMX	136.16	136.16	0	201.49	9.00
10.00		RML	125.88	125.88	0	184.83	10.00
11.00		RLX	96.39	96.39	0	117.63	11.00
12.00		RUC	169.51	169.51	0	201.03	12.00
13.00		RUB	156.99	156.99	0	201.03	13.00
14.00		RUA	150.72	150.72	0	165.39	14.00
15.00		RVC	132.66	132.66	0	172.50	15.00
16.00		RVB	126.85	126.85	0	147.98	16.00
17.00		RVA	116.12	116.12	0	147.51	17.00
18.00		RHC	113.11	113.11	0	150.71	18.00
19.00		RHB	108.63	108.63	0	134.98	19.00
20.00		RHA	101.92	101.92	0	117.85	20.00
21.00		RMC	103.51	103.51	0	133.00	21.00
22.00		RMB	100.82	100.82	0	123.74	22.00
23.00		RMA	99.04	99.04	0	100.60	23.00
24.00		RLB	89.24	89.24	0	129.97	24.00
25.00		RLA	77.16	77.16	0	80.92	25.00
26.00		ES3	195.98	195.98	0	195.98	26.00
27.00		ES2	153.87	153.87	0	153.87	27.00
28.00		ES1	137.67	137.67	0	137.67	28.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-7 | Date/Time Prepared: 12/19/2011 9:46 am

		Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate On/After 10/1	
		1.00	2.00	3.00	4.00	5.00	
29.00		HE2	133.04	133.04	0	133.04	29.00
30.00		HE1	110.83	110.83	0	110.83	30.00
31.00		HD2	124.71	124.71	0	124.71	31.00
32.00		HD1	104.35	104.35	0	104.35	32.00
33.00		HC2	117.77	117.77	0	117.77	33.00
34.00		HC1	98.80	98.80	0	98.80	34.00
35.00		HB2	116.38	116.38	0	116.38	35.00
36.00		HB1	97.87	97.87	0	97.87	36.00
37.00		LE2	121.01	121.01	0	121.01	37.00
38.00		LE1	101.57	101.57	0	101.57	38.00
39.00		LD2	116.38	116.38	0	116.38	39.00
40.00		LD1	97.87	97.87	0	97.87	40.00
41.00		LC2	102.50	102.50	0	102.50	41.00
42.00		LC1	86.76	86.76	0	86.76	42.00
43.00		LB2	97.41	97.41	0	97.41	43.00
44.00		LB1	83.06	83.06	0	83.06	44.00
45.00		CE2	108.05	108.05	0	108.05	45.00
46.00		CE1	99.72	99.72	0	99.72	46.00
47.00		CD2	102.50	102.50	0	102.50	47.00
48.00		CD1	94.17	94.17	0	94.17	48.00
49.00		CC2	79.84	79.84	0	90.00	49.00
50.00		CC1	73.58	73.58	0	83.53	50.00
51.00		CB2	70.00	70.00	0	83.53	51.00
52.00		CB1	66.87	66.87	0	77.51	52.00
53.00		CA2	66.42	66.42	0	71.03	53.00
54.00		CA1	62.84	62.84	0	66.40	54.00
55.00		SE3	106.23	106.23	0	0.00	55.00
56.00		SE2	91.03	91.03	0	0.00	56.00
57.00		SE1	81.63	81.63	0	0.00	57.00
58.00		SSC	80.29	80.29	0	0.00	58.00
59.00		SSB	76.27	76.27	0	0.00	59.00
60.00		SSA	74.92	74.92	0	0.00	60.00
61.00		IB2	60.16	60.16	0	0.00	61.00
62.00		IB1	59.27	59.27	0	0.00	62.00
63.00		IA2	54.79	54.79	0	0.00	63.00
64.00		IA1	53.00	53.00	0	0.00	64.00
65.00		BB2	59.71	59.71	0	75.20	65.00
66.00		BB1	58.37	58.37	0	71.96	66.00
67.00		BA2	54.35	54.35	0	62.70	67.00
68.00		BA1	50.77	50.77	0	59.93	68.00
69.00		PE2	64.63	64.63	0	99.72	69.00
70.00		PE1	63.74	63.74	0	95.10	70.00
71.00		PD2	61.50	61.50	0	94.17	71.00
72.00		PD1	60.61	60.61	0	89.54	72.00
73.00		PC2	58.82	58.82	0	81.21	73.00
74.00		PC1	58.37	58.37	0	77.51	74.00
75.00		PB2	52.56	52.56	0	69.18	75.00
76.00		PB1	51.66	51.66	0	66.40	76.00
77.00		PA2	51.21	51.21	0	57.61	77.00
78.00		PA1	49.87	49.87	0	55.30	78.00
199.00		AAA	49.87	49.87	0	0.00	199.00
200.00	TOTAL				0		200.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-7 | Date/Time Prepared: 12/19/2011 9:46 am

		Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total		
		6.00	7.00	8.00		
3.00		269.98	0	0		3.00
4.00		263.50	0	0		4.00
5.00		241.45	0	0		5.00
6.00		215.54	0	0		6.00
7.00		219.66	0	0		7.00
8.00		194.67	0	0		8.00
9.00		201.49	0	0		9.00
10.00		184.83	0	0		10.00
11.00		117.63	0	0		11.00
12.00		201.03	0	0		12.00
13.00		201.03	0	0		13.00
14.00		165.39	0	0		14.00
15.00		172.50	0	0		15.00
16.00		147.98	0	0		16.00
17.00		147.51	0	0		17.00
18.00		150.71	0	0		18.00
19.00		134.98	0	0		19.00
20.00		117.85	0	0		20.00
21.00		133.00	0	0		21.00
22.00		123.74	0	0		22.00
23.00		100.60	0	0		23.00
24.00		129.97	0	0		24.00
25.00		80.92	0	0		25.00
26.00		195.98	0	0		26.00
27.00		153.87	0	0		27.00
28.00		137.67	0	0		28.00
29.00		133.04	0	0		29.00
30.00		110.83	0	0		30.00
31.00		124.71	0	0		31.00
32.00		104.35	0	0		32.00
33.00		117.77	0	0		33.00
34.00		98.80	0	0		34.00
35.00		116.38	0	0		35.00
36.00		97.87	0	0		36.00
37.00		121.01	0	0		37.00
38.00		101.57	0	0		38.00
39.00		116.38	0	0		39.00
40.00		97.87	0	0		40.00
41.00		102.50	0	0		41.00
42.00		86.76	0	0		42.00
43.00		97.41	0	0		43.00
44.00		83.06	0	0		44.00
45.00		108.05	0	0		45.00
46.00		99.72	0	0		46.00
47.00		102.50	0	0		47.00
48.00		94.17	0	0		48.00
49.00		90.00	0	0		49.00
50.00		83.53	0	0		50.00
51.00		83.53	0	0		51.00
52.00		77.51	0	0		52.00
53.00		71.03	0	0		53.00
54.00		66.40	0	0		54.00
55.00		0.00	0	0		55.00
56.00		0.00	0	0		56.00
57.00		0.00	0	0		57.00
58.00		0.00	0	0		58.00
59.00		0.00	0	0		59.00
60.00		0.00	0	0		60.00
61.00		0.00	0	0		61.00
62.00		0.00	0	0		62.00
63.00		0.00	0	0		63.00
64.00		0.00	0	0		64.00
65.00		75.20	0	0		65.00
66.00		71.96	0	0		66.00
67.00		62.70	0	0		67.00
68.00		59.93	0	0		68.00
69.00		99.72	0	0		69.00
70.00		95.10	0	0		70.00
71.00		94.17	0	0		71.00
72.00		89.54	0	0		72.00
73.00		81.21	0	0		73.00
74.00		77.51	0	0		74.00
75.00		69.18	0	0		75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet S-7 Date/Time Prepared: 12/19/2011 9:46 am

		Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total		
		6.00	7.00	8.00		
76.00		66.40	0	0		76.00
77.00		57.61	0	0		77.00
78.00		55.30	0	0		78.00
199.00		0.00	0	0		199.00
200.00	TOTAL		0	0		200.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-8 | Date/Time Prepared: 12/19/2011 9:46 am

Rural Health Clinic (RHC) I | Cost

					1.00	
	Clinic Address and Identification					
1.00	Street			303 NORTH JACKSON STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	MORRISON		IL	61270	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
9.01				0		9.01
9.02				0		9.02
9.03				0		9.03
9.04				0		9.04
9.05				0		9.05
9.06				0		9.06
9.07				0		9.07
9.08				0		9.08
9.09				0		9.09
9.10				0		9.10
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday			
		from	to	from	to		
		1.00	2.00	3.00	4.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00		11.00

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

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

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/19/2011 9:46 am

		Rural Health Clinic (RHC) I	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	WHITESIDE					2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/19/2011 9:46 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	08:00	20:00	08:00	20:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/19/2011 9:46 am
		Rural Health Clinic (RHC) I	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 12/19/2011 9:46 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)	0.820471	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,581,659	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	2,903,289	6.00
7.00	Medicaid cost (line 1 times line 6)	2,382,064	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)	800,405	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)	800,405	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	79,123	12,989	92,112	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	64,918	10,657	75,575	21.00
22.00	Partial payment by patients approved for charity care	10,043	468	10,511	22.00
23.00	Cost of charity care (line 21 minus line 22)	54,875	10,189	65,064	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)	806,011	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	52,781	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	753,230	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	618,003	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	683,067	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,483,472	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 12/19/2011 9:46 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		546,214	546,214	-132,350	413,864	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		0	0	316,167	316,167	2.00
3.00	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	EMPLOYEE BENEFITS	0	1,203,153	1,203,153	0	1,203,153	4.00
5.01	PURCHASING	31,148	5,366	36,514	0	36,514	5.01
5.02	PERSONNEL	103,410	26,546	129,956	0	129,956	5.02
5.03	HOSPITAL BILLING	227,453	119,362	346,815	0	346,815	5.03
5.04	NURSING HOME BILLING	150	87	237	0	237	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	342,213	689,958	1,032,171	158,099	1,190,270	5.05
7.00	OPERATION OF PLANT	138,304	355,074	493,378	0	493,378	7.00
8.00	LAUNDRY & LINEN SERVICE	0	51,559	51,559	0	51,559	8.00
9.00	HOUSEKEEPING	166,296	43,252	209,548	0	209,548	9.00
10.00	DIETARY	189,087	111,043	300,130	0	300,130	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	105,252	5,540	110,792	0	110,792	13.00
14.00	CENTRAL SERVICES & SUPPLY	15,904	5,770	21,674	0	21,674	14.00
16.00	MEDICAL RECORDS & LIBRARY	166,770	20,873	187,643	0	187,643	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	3,972	426	4,398	0	4,398	16.01
17.00	SOCIAL SERVICE	54,603	677	55,280	0	55,280	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	949,729	200,800	1,150,529	0	1,150,529	30.00
44.00	SKILLED NURSING FACILITY	690,484	97,299	787,783	0	787,783	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	125,063	174,721	299,784	-13,181	286,603	50.00
53.00	ANESTHESIOLOGY	0	52,385	52,385	0	52,385	53.00
54.00	RADIOLOGY-DIAGNOSTIC	189,174	58,973	248,147	690	248,837	54.00
60.00	LABORATORY	295,324	237,760	533,084	2,445	535,529	60.00
65.00	RESPIRATORY THERAPY	0	29,939	29,939	0	29,939	65.00
66.00	PHYSICAL THERAPY	252,204	8,230	260,434	0	260,434	66.00
67.00	OCCUPATIONAL THERAPY	118,319	5,211	123,530	1,275	124,805	67.00
68.00	SPEECH PATHOLOGY	556	2,795	3,351	-1,275	2,076	68.00
69.00	ELECTROCARDIOLOGY	3,668	5,743	9,411	0	9,411	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,553	21,553	-1,406	20,147	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	14,979	14,979	72.00
73.00	DRUGS CHARGED TO PATIENTS	119,697	317,597	437,294	0	437,294	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	609,253	717,111	1,326,364	-110,790	1,215,574	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	345,589	617,498	963,087	-84,047	879,040	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	100,760	47,136	147,896	-5,542	142,354	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE		145,064	145,064	-145,064	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,344,382	5,924,715	11,269,097	0	11,269,097	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00	TOTAL (SUM OF LINES 118-199)	5,344,382	5,924,715	11,269,097	0	11,269,097	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 12/19/2011 9:46 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	-12,731	401,133		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-2,817	313,350		2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	EMPLOYEE BENEFITS	-2,403	1,200,750		4.00
5.01	PURCHASING	0	36,514		5.01
5.02	PERSONNEL	0	129,956		5.02
5.03	HOSPITAL BILLING	-5,473	341,342		5.03
5.04	NURSING HOME BILLING	0	237		5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	-59,787	1,130,483		5.05
7.00	OPERATION OF PLANT	0	493,378		7.00
8.00	LAUNDRY & LINEN SERVICE	0	51,559		8.00
9.00	HOUSEKEEPING	0	209,548		9.00
10.00	DIETARY	-24,665	275,465		10.00
11.00	CAFETERIA	0	0		11.00
13.00	NURSING ADMINISTRATION	0	110,792		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	21,674		14.00
16.00	MEDICAL RECORDS & LIBRARY	-2,824	184,819		16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	0	4,398		16.01
17.00	SOCIAL SERVICE	0	55,280		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-5,018	1,145,511		30.00
44.00	SKILLED NURSING FACILITY	0	787,783		44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-7,650	278,953		50.00
53.00	ANESTHESIOLOGY	-540	51,845		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-8,670	240,167		54.00
60.00	LABORATORY	-26,796	508,733		60.00
65.00	RESPIRATORY THERAPY	-112	29,827		65.00
66.00	PHYSICAL THERAPY	-3,136	257,298		66.00
67.00	OCCUPATIONAL THERAPY	-764	124,041		67.00
68.00	SPEECH PATHOLOGY	0	2,076		68.00
69.00	ELECTROCARDIOLOGY	-6,001	3,410		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-99	20,048		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	14,979		72.00
73.00	DRUGS CHARGED TO PATIENTS	-2,341	434,953		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-95,259	1,120,315		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	-145,226	733,814		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	-2,219	140,135		95.00
99.10	CORF	0	0		99.10
	SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0		110.00
111.00	ISLET ACQUISITION	0	0		111.00
113.00	INTEREST EXPENSE	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-414,531	10,854,566		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	RENTAL HOUSE	0	0		194.00
194.01	RENTAL SPACE	0	0		194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.02
200.00	TOTAL (SUM OF LINES 118-199)	-414,531	10,854,566		200.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 12/19/2011 9:46 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	139,806		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	814		2.00
3.00	AMBULANCE SERVICES	95.00	0	1,309		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	690		4.00
5.00	LABORATORY	60.00	0	2,445		5.00
	TOTALS		0	145,064		
	B - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	36,987		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	7,024		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	157,285		3.00
	TOTALS		0	201,296		
	C - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	309,143		1.00
	TOTALS		0	309,143		
	D - OCCUPATIONAL THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	1,275		1.00
	TOTALS		0	1,275		
	E - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	14,979		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	14,979		
500.00	Grand Total: Increases		0	671,757		500.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 12/19/2011 9:46 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	145,064	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	145,064			
	B - INSURANCE						
1.00	RURAL HEALTH CLINIC	88.00	0	110,398	12		1.00
2.00	EMERGENCY	91.00	0	84,047	12		2.00
3.00	AMBULANCE SERVICES	95.00	0	6,851	0		3.00
	TOTALS		0	201,296			
	C - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	309,143	9		1.00
	TOTALS		0	309,143			
	D - OCCUPATIONAL THERAPY						
1.00	SPEECH PATHOLOGY	68.00	0	1,275	0		1.00
	TOTALS		0	1,275			
	E - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	13,181	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,406	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	392	0		3.00
	TOTALS		0	14,979			
500.00	Grand Total: Decreases		0	671,757			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/19/2011 9:46 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	21,657	0	0	0	0	1.00
2.00	Land Improvements	388,120	119,827	0	119,827	0	2.00
3.00	Buildings and Fixtures	7,480,335	161,055	0	161,055	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	328,274	0	0	0	0	5.00
6.00	Movable Equipment	3,487,788	220,923	0	220,923	82,987	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	11,706,174	501,805	0	501,805	82,987	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	11,706,174	501,805	0	501,805	82,987	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	546,214	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	546,214	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	8,499,268	0	8,499,268	0.700971	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,625,724	0	3,625,724	0.299029	0	2.00
3.00	Total (sum of lines 1-2)	12,124,992	0	12,124,992	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/19/2011 9:46 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	21,657	0				1.00
2.00	Land Improvements	507,947	0				2.00
3.00	Buildings and Fixtures	7,641,390	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	328,274	0				5.00
6.00	Movable Equipment	3,625,724	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	12,124,992	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	12,124,992	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	546,214				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	546,214				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	237,071	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	306,326	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	543,397	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 12/19/2011 9:46 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	127,075	36,987	0	0	401,133	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	7,024	0	0	313,350	2.00
3.00	Total (sum of lines 1-2)	127,075	44,011	0	0	714,483	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 12/19/2011 9:46 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - buildings and fixtures (chapter 2)	B	-12,731	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	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)	A	-4,046	OTHER ADMINISTRATIVE AND GENERAL	5.05	7.00
8.00	Television and radio service (chapter 21)	A	-2,817	NEW CAP REL COSTS-MVBLE EQUIP	2.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-193,161			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-22,939	DIETARY	10.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-2,824	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 - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	LAB OTHER REVENUE	B	-13,603	LABORATORY	60.00	33.00
34.00	PV MEDICAL DIRECTOR INCOME	B	-24,000	RURAL HEALTH CLINIC	88.00	34.00
35.00	INVESTMENT INCOME-OTHER	B	-74	OTHER ADMINISTRATIVE AND GENERAL	5.05	35.00
36.00	INVESTMENT INCOME-OTHER	B	-119	ADULTS & PEDIATRICS	30.00	36.00
37.00	INVESTMENT INCOME-OTHER	B	-63	RADIOLOGY-DIAGNOSTIC	54.00	37.00
38.00	INVESTMENT INCOME-OTHER	B	-223	LABORATORY	60.00	38.00
39.00	OTHER REV -A&G	B	-1,913	OTHER ADMINISTRATIVE AND GENERAL	5.05	39.00
40.00	OTHER REV - DIETARY	B	-1,726	DIETARY	10.00	40.00
41.00	OTHER REV - DRUGS	B	-60	DRUGS CHARGED TO PATIENTS	73.00	41.00
42.00	OTHER REV - AMBULANCE	B	-540	AMBULANCE SERVICES	95.00	42.00
43.00	NONALLOWABLE DUES	A	-3,899	OTHER ADMINISTRATIVE AND GENERAL	5.05	43.00
44.00	PATIENT TELEPHONE - SALARIES	A	-5,203	OTHER ADMINISTRATIVE AND GENERAL	5.05	44.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 12/19/2011 9:46 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
45.00	PATIENT TELEPHONE - BENEFITS	A	-1,171	EMPLOYEE BENEFITS	4.00	45.00
45.01	PHYSICIAN BILLING SALARIES	A	-5,473	HOSPITAL BILLING	5.03	45.01
45.02	PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-1,232	EMPLOYEE BENEFITS	4.00	45.02
45.03	ADVERTISING	A	-44,527	OTHER ADMINISTRATIVE AND GENERAL	5.05	45.03
45.04	SELF INSURANCE EXPENSE	A	-3,511	ADULTS & PEDIATRICS	30.00	45.04
45.05	SELF INSURANCE EXPENSE	A	-7,650	OPERATING ROOM	50.00	45.05
45.06	SELF INSURANCE EXPENSE	A	-540	ANESTHESIOLOGY	53.00	45.06
45.07	SELF INSURANCE EXPENSE	A	-8,607	RADIOLOGY-DIAGNOSTIC	54.00	45.07
45.08	SELF INSURANCE EXPENSE	A	-12,970	LABORATORY	60.00	45.08
45.09	SELF INSURANCE EXPENSE	A	-112	RESPIRATORY THERAPY	65.00	45.09
45.10	SELF INSURANCE EXPENSE	A	-3,136	PHYSICAL THERAPY	66.00	45.10
45.11	SELF INSURANCE EXPENSE	A	-764	OCCUPATIONAL THERAPY	67.00	45.11
45.12	SELF INSURANCE EXPENSE	A	-262	ELECTROCARDIOLOGY	69.00	45.12
45.13	SELF INSURANCE EXPENSE	A	-99	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	45.13
45.14	SELF INSURANCE EXPENSE	A	-2,281	DRUGS CHARGED TO PATIENTS	73.00	45.14
45.15	SELF INSURANCE EXPENSE	A	-10,336	EMERGENCY	91.00	45.15
45.16	SELF INSURANCE EXPENSE	A	-1,388	ADULTS & PEDIATRICS	30.00	45.16
45.17	SELF INSURANCE EXPENSE	A	-18,727	RURAL HEALTH CLINIC	88.00	45.17
45.18	SELF INSURANCE EXPENSE	A	-1,679	AMBULANCE SERVICES	95.00	45.18
45.19	OTHER REV-EDUCATION	A	-125	OTHER ADMINISTRATIVE AND GENERAL	5.05	45.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-414,531			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 12/19/2011 9:46 am

		Wkst. A-7 Ref. 5.00		
1.00	Investment income - buildings and fixtures (chapter 2)	11		1.00
2.00	Investment income - movable equipment (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	9		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - buildings and fixtures	0		26.00
27.00	Depreciation - movable equipment	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	LAB OTHER REVENUE	0		33.00
34.00	PV MEDICAL DIRECTOR INCOME	0		34.00
35.00	INVESTMENT INCOME-OTHER	0		35.00
36.00	INVESTMENT INCOME-OTHER	0		36.00
37.00	INVESTMENT INCOME-OTHER	0		37.00
38.00	INVESTMENT INCOME-OTHER	0		38.00
39.00	OTHER REV -A&G	0		39.00
40.00	OTHER REV - DIETARY	0		40.00
41.00	OTHER REV - DRUGS	0		41.00
42.00	OTHER REV - AMBULANCE	0		42.00
43.00	NONALLOWABLE DUES	0		43.00
44.00	PATIENT TELEPHONE - SALARIES	0		44.00
45.00	PATIENT TELEPHONE - BENEFITS	0		45.00
45.01	PHYSICIAN BILLING SALARIES	0		45.01
45.02	PHYSICIAN BILLING EMPLOYEE BENEFITS	0		45.02
45.03	ADVERTISING	0		45.03
45.04	SELF INSURANCE EXPENSE	0		45.04
45.05	SELF INSURANCE EXPENSE	0		45.05
45.06	SELF INSURANCE EXPENSE	0		45.06
45.07	SELF INSURANCE EXPENSE	0		45.07
45.08	SELF INSURANCE EXPENSE	0		45.08
45.09	SELF INSURANCE EXPENSE	0		45.09
45.10	SELF INSURANCE EXPENSE	0		45.10
45.11	SELF INSURANCE EXPENSE	0		45.11
45.12	SELF INSURANCE EXPENSE	0		45.12
45.13	SELF INSURANCE EXPENSE	0		45.13

ADJUSTMENTS TO EXPENSES	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8 Date/Time Prepared: 12/19/2011 9:46 am

		Wkst. A-7 Ref.		
		5.00		
45.14	SELF INSURANCE EXPENSE	0		45.14
45.15	SELF INSURANCE EXPENSE	0		45.15
45.16	SELF INSURANCE EXPENSE	0		45.16
45.17	SELF INSURANCE EXPENSE	0		45.17
45.18	SELF INSURANCE EXPENSE	0		45.18
45.19	OTHER REV-EDUCATION	0		45.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 12/19/2011 9:46 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	ER PHYSICIAN FEES	452,980	134,890	1.00
2.00		91.00	ER MEDICAL DIRECTOR FEES	3,100	0	2.00
3.00		69.00	EKG FEES	5,739	5,739	3.00
4.00		88.00	ER/ACUTE FEES	52,532	52,532	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
200.00			TOTAL (lines 1.00 through 199.00)	514,351	193,161	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 12/19/2011 9:46 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		318,090	0	0	0	0	1.00
2.00		3,100	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		321,190		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 12/19/2011 9:46 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: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 12/19/2011 9:46 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	134,890		1.00
2.00		0	0		2.00
3.00		0	5,739		3.00
4.00		0	52,532		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	193,161		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 12/19/2011 9:46 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		1	1.00
2.00	Line 1 multiplied by 15 hours per week		15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		4	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.00	7.00
8.00	Optional travel expense rate per mile		0.50	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	21.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.79	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.40	34.40	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	1,445	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	1,445	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	1,445	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	1,445	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	138	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	138	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	20	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	158	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	158	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 12/19/2011 9:46 am
		Occupational Therapy	Cost

						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.79	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	1,445		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	158		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	1,603		63.00
64.00	Total cost of outside supplier services (from your records)	1,275		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	138		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	20		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	158		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	20		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	20		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 12/19/2011 9:46 am

Speech Pathology — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					11	1.00
2.00	Line 1 multiplied by 15 hours per week					165	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					21	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.00	7.00
8.00	Optional travel expense rate per mile					0.50	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	17.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	66.10	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.05	33.05	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,124	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,124	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					1,124	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					66.12	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					10,910	22.00
23.00	Total salary equivalency (see instructions)					10,910	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					694	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					694	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					105	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					799	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					799	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-3 Par | Date/Time Prepared: 12/19/2011 9:46 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.10	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	10,910		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	799		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	11,709		63.00
64.00	Total cost of outside supplier services (from your records)	1,145		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	694		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	105		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	799		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	105		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	105		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 12/19/2011 9:46 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	PURCHASING	
		0	1.00	2.00	4.00	5.01	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	401,133	401,133				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	313,350		313,350			2.00
4.00	EMPLOYEE BENEFITS	1,200,750	0	0	1,200,750		4.00
5.01	PURCHASING	36,514	11,684	0	6,998	55,196	5.01
5.02	PERSONNEL	129,956	3,715	676	23,234	918	5.02
5.03	HOSPITAL BILLING	341,342	6,415	4,205	51,103	1,538	5.03
5.04	NURSING HOME BILLING	237	649	0	34	0	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	1,130,483	19,357	20,641	76,887	2,916	5.05
7.00	OPERATION OF PLANT	493,378	72,233	4,068	31,073	1,424	7.00
8.00	LAUNDRY & LINEN SERVICE	51,559	9,198	0	0	23	8.00
9.00	HOUSEKEEPING	209,548	3,840	0	37,363	1,538	9.00
10.00	DIETARY	275,465	10,642	646	42,483	1,401	10.00
11.00	CAFETERIA	0	4,095	0	0	0	11.00
13.00	NURSING ADMINISTRATION	110,792	5,435	0	23,647	804	13.00
14.00	CENTRAL SERVICES & SUPPLY	21,674	3,591	0	3,573	9,069	14.00
16.00	MEDICAL RECORDS & LIBRARY	184,819	8,453	2,412	37,469	1,401	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	4,398	691	0	892	0	16.01
17.00	SOCIAL SERVICE	55,280	1,057	0	12,268	23	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,145,511	64,638	49,644	213,382	5,028	30.00
44.00	SKILLED NURSING FACILITY	787,783	60,909	1,726	155,134	4,202	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	278,953	14,468	91,827	28,099	3,765	50.00
53.00	ANESTHESIOLOGY	51,845	0	0	0	298	53.00
54.00	RADIOLOGY-DIAGNOSTIC	240,167	9,620	49,776	42,503	1,929	54.00
60.00	LABORATORY	508,733	9,709	36,559	66,352	3,605	60.00
65.00	RESPIRATORY THERAPY	29,827	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	257,298	10,006	1,368	56,664	1,171	66.00
67.00	OCCUPATIONAL THERAPY	124,041	3,418	0	26,583	0	67.00
68.00	SPEECH PATHOLOGY	2,076	0	0	125	0	68.00
69.00	ELECTROCARDIOLOGY	3,410	0	691	824	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,048	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	14,979	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	434,953	3,342	7,831	26,893	551	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,120,315	35,855	6,176	136,884	4,982	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	733,814	8,639	12,499	77,645	5,005	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	140,135	19,474	22,605	22,638	3,605	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,854,566	401,133	313,350	1,200,750	55,196	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	10,854,566	401,133	313,350	1,200,750	55,196	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
		5.02	5.03	5.04	5A.04	5.05	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	PURCHASING						5.01
5.02	PERSONNEL	158,499					5.02
5.03	HOSPITAL BILLING	6,920	411,523				5.03
5.04	NURSING HOME BILLING	5	0	925			5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	10,411	0	0	1,260,695	1,260,695	5.05
7.00	OPERATION OF PLANT	4,208	0	0	606,384	79,682	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	60,780	7,987	8.00
9.00	HOUSEKEEPING	5,059	0	0	257,348	33,817	9.00
10.00	DIETARY	5,753	0	0	336,390	44,204	10.00
11.00	CAFETERIA	0	0	0	4,095	538	11.00
13.00	NURSING ADMINISTRATION	3,202	0	0	143,880	18,907	13.00
14.00	CENTRAL SERVICES & SUPPLY	484	0	0	38,391	5,045	14.00
16.00	MEDICAL RECORDS & LIBRARY	5,074	0	0	239,628	31,489	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	121	0	0	6,102	802	16.01
17.00	SOCIAL SERVICE	1,661	0	0	70,289	9,236	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	28,891	50,318	0	1,557,412	204,655	30.00
44.00	SKILLED NURSING FACILITY	21,007	0	925	1,031,686	135,570	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,805	21,483	0	442,400	58,134	50.00
53.00	ANESTHESIOLOGY	0	4,585	0	56,728	7,454	53.00
54.00	RADIOLOGY-DIAGNOSTIC	5,755	55,062	0	404,812	53,195	54.00
60.00	LABORATORY	8,985	56,179	0	690,122	90,686	60.00
65.00	RESPIRATORY THERAPY	0	6,614	0	36,441	4,789	65.00
66.00	PHYSICAL THERAPY	7,673	38,354	0	372,534	48,953	66.00
67.00	OCCUPATIONAL THERAPY	3,600	16,777	0	174,419	22,920	67.00
68.00	SPEECH PATHOLOGY	17	322	0	2,540	334	68.00
69.00	ELECTROCARDIOLOGY	112	3,078	0	8,115	1,066	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	912	0	20,960	2,754	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	2,092	0	17,071	2,243	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,642	53,959	0	531,171	69,799	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	18,535	69,797	0	1,392,544	182,989	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	10,514	18,372	0	866,488	113,862	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	3,065	13,619	0	225,141	29,585	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	158,499	411,523	925	10,854,566	1,260,695	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	158,499	411,523	925	10,854,566	1,260,695	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	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
5.01	PURCHASING						5.01
5.02	PERSONNEL						5.02
5.03	HOSPITAL BILLING						5.03
5.04	NURSING HOME BILLING						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	OPERATION OF PLANT	686,066					7.00
8.00	LAUNDRY & LINEN SERVICE	21,983	90,750				8.00
9.00	HOUSEKEEPING	9,176	0	300,341			9.00
10.00	DIETARY	25,432	0	1,617	407,643		10.00
11.00	CAFETERIA	9,787	0	0	81,292	95,712	11.00
13.00	NURSING ADMINISTRATION	12,988	0	3,508	0	2,272	13.00
14.00	CENTRAL SERVICES & SUPPLY	8,582	0	5,095	0	390	14.00
16.00	MEDICAL RECORDS & LIBRARY	20,200	0	5,457	0	5,125	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	1,650	0	980	0	120	16.01
17.00	SOCIAL SERVICE	2,525	0	1,499	0	1,001	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	154,471	18,982	90,128	64,781	22,271	30.00
44.00	SKILLED NURSING FACILITY	145,561	59,151	83,203	260,866	22,482	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	34,575	1,464	13,550	0	3,003	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	22,989	2,693	12,081	0	3,864	54.00
60.00	LABORATORY	23,204	0	13,776	0	6,336	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	23,914	1,435	14,197	0	3,774	66.00
67.00	OCCUPATIONAL THERAPY	8,169	0	4,850	0	1,181	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	7,988	0	3,978	0	1,762	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	85,686	1,076	34,165	0	10,520	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	20,646	5,567	12,257	0	9,129	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	46,540	382	0	0	2,482	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	686,066	90,750	300,341	406,939	95,712	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	704	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	686,066	90,750	300,341	407,643	95,712	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBRA	SOCIAL SERVICE	
		13.00	14.00	16.00	16.01	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	PURCHASING						5.01
5.02	PERSONNEL						5.02
5.03	HOSPITAL BILLING						5.03
5.04	NURSING HOME BILLING						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	181,555					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	57,503				14.00
16.00	MEDICAL RECORDS & LIBRARY	0	2,264	304,163			16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	0	0	0	9,654		16.01
17.00	SOCIAL SERVICE	3,308	37	0	0	87,895	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	73,343	8,131	37,191	0	58,133	30.00
44.00	SKILLED NURSING FACILITY	0	6,793	0	9,654	29,762	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	9,906	6,088	15,879	0	0	50.00
53.00	ANESTHESIOLOGY	0	483	3,389	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,118	40,698	0	0	54.00
60.00	LABORATORY	0	5,828	41,524	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	4,889	0	0	65.00
66.00	PHYSICAL THERAPY	12,418	1,893	28,349	0	0	66.00
67.00	OCCUPATIONAL THERAPY	3,886	0	12,400	0	0	67.00
68.00	SPEECH PATHOLOGY	16	0	238	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	2,275	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	674	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	1,546	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,802	891	39,883	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	34,632	8,056	51,582	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	30,061	8,093	13,579	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	8,183	5,828	10,067	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	181,555	57,503	304,163	9,654	87,895	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	181,555	57,503	304,163	9,654	87,895	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.01	PURCHASING					5.01
5.02	PERSONNEL					5.02
5.03	HOSPITAL BILLING					5.03
5.04	NURSING HOME BILLING					5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA					16.01
17.00	SOCIAL SERVICE					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	2,289,498	0	2,289,498		30.00
44.00	SKILLED NURSING FACILITY	1,784,728	0	1,784,728		44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	584,999	0	584,999		50.00
53.00	ANESTHESIOLOGY	68,054	0	68,054		53.00
54.00	RADIOLOGY-DIAGNOSTIC	543,450	0	543,450		54.00
60.00	LABORATORY	871,476	0	871,476		60.00
65.00	RESPIRATORY THERAPY	46,119	0	46,119		65.00
66.00	PHYSICAL THERAPY	507,467	0	507,467		66.00
67.00	OCCUPATIONAL THERAPY	227,825	0	227,825		67.00
68.00	SPEECH PATHOLOGY	3,128	0	3,128		68.00
69.00	ELECTROCARDIOLOGY	11,456	0	11,456		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,388	0	24,388		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	20,860	0	20,860		72.00
73.00	DRUGS CHARGED TO PATIENTS	661,274	0	661,274		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	1,801,250	0	1,801,250		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	1,079,682	0	1,079,682		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	328,208	0	328,208		95.00
99.10	CORF	0	0	0		99.10
	SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0		111.00
113.00	INTEREST EXPENSE	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,853,862	0	10,853,862		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	RENTAL HOUSE	0	0	0		194.00
194.01	RENTAL SPACE	0	0	0		194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	704	0	704		194.02
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	10,854,566	0	10,854,566		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 12/19/2011 9:46 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	0	0	0	0	4.00
5.01	PURCHASING	0	11,684	0	11,684	0	5.01
5.02	PERSONNEL	0	3,715	676	4,391	0	5.02
5.03	HOSPITAL BILLING	0	6,415	4,205	10,620	0	5.03
5.04	NURSING HOME BILLING	0	649	0	649	0	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	0	19,357	20,641	39,998	0	5.05
7.00	OPERATION OF PLANT	0	72,233	4,068	76,301	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	9,198	0	9,198	0	8.00
9.00	HOUSEKEEPING	0	3,840	0	3,840	0	9.00
10.00	DIETARY	0	10,642	646	11,288	0	10.00
11.00	CAFETERIA	0	4,095	0	4,095	0	11.00
13.00	NURSING ADMINISTRATION	0	5,435	0	5,435	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	3,591	0	3,591	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	0	8,453	2,412	10,865	0	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	0	691	0	691	0	16.01
17.00	SOCIAL SERVICE	0	1,057	0	1,057	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	64,638	49,644	114,282	0	30.00
44.00	SKILLED NURSING FACILITY	0	60,909	1,726	62,635	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	14,468	91,827	106,295	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	9,620	49,776	59,396	0	54.00
60.00	LABORATORY	0	9,709	36,559	46,268	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	10,006	1,368	11,374	0	66.00
67.00	OCCUPATIONAL THERAPY	0	3,418	0	3,418	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	691	691	0	69.00
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	3,342	7,831	11,173	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	35,855	6,176	42,031	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	8,639	12,499	21,138	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	19,474	22,605	42,079	0	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	401,133	313,350	714,483	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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	401,133	313,350	714,483	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	PURCHASING	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	OTHER ADMINISTRATIVE AND GENERAL	
		5.01	5.02	5.03	5.04	5.05	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	PURCHASING	11,684					5.01
5.02	PERSONNEL	194	4,585				5.02
5.03	HOSPITAL BILLING	326	200	11,146			5.03
5.04	NURSING HOME BILLING	0	0	0	649		5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	617	301	0	0	40,916	5.05
7.00	OPERATION OF PLANT	301	122	0	0	2,586	7.00
8.00	LAUNDRY & LINEN SERVICE	5	0	0	0	259	8.00
9.00	HOUSEKEEPING	326	146	0	0	1,098	9.00
10.00	DIETARY	296	166	0	0	1,435	10.00
11.00	CAFETERIA	0	0	0	0	17	11.00
13.00	NURSING ADMINISTRATION	170	93	0	0	614	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,921	14	0	0	164	14.00
16.00	MEDICAL RECORDS & LIBRARY	296	147	0	0	1,022	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	0	3	0	0	26	16.01
17.00	SOCIAL SERVICE	5	48	0	0	300	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,064	838	1,363	0	6,640	30.00
44.00	SKILLED NURSING FACILITY	889	608	0	649	4,400	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	797	110	582	0	1,887	50.00
53.00	ANESTHESIOLOGY	63	0	124	0	242	53.00
54.00	RADIOLOGY-DIAGNOSTIC	408	166	1,491	0	1,727	54.00
60.00	LABORATORY	763	260	1,522	0	2,943	60.00
65.00	RESPIRATORY THERAPY	0	0	179	0	155	65.00
66.00	PHYSICAL THERAPY	248	222	1,039	0	1,589	66.00
67.00	OCCUPATIONAL THERAPY	0	104	454	0	744	67.00
68.00	SPEECH PATHOLOGY	0	0	9	0	11	68.00
69.00	ELECTROCARDIOLOGY	0	3	83	0	35	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	25	0	89	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	57	0	73	72.00
73.00	DRUGS CHARGED TO PATIENTS	117	105	1,462	0	2,265	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,055	536	1,889	0	5,939	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,060	304	498	0	3,696	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	763	89	369	0	960	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,684	4,585	11,146	649	40,916	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	11,684	4,585	11,146	649	40,916	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	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
5.01	PURCHASING						5.01
5.02	PERSONNEL						5.02
5.03	HOSPITAL BILLING						5.03
5.04	NURSING HOME BILLING						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	OPERATION OF PLANT	79,310					7.00
8.00	LAUNDRY & LINEN SERVICE	2,541	12,003				8.00
9.00	HOUSEKEEPING	1,061	0	6,471			9.00
10.00	DIETARY	2,940	0	35	16,160		10.00
11.00	CAFETERIA	1,131	0	0	3,223	8,466	11.00
13.00	NURSING ADMINISTRATION	1,501	0	76	0	201	13.00
14.00	CENTRAL SERVICES & SUPPLY	992	0	110	0	35	14.00
16.00	MEDICAL RECORDS & LIBRARY	2,335	0	118	0	453	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	191	0	21	0	11	16.01
17.00	SOCIAL SERVICE	292	0	32	0	89	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	17,859	2,511	1,941	2,568	1,970	30.00
44.00	SKILLED NURSING FACILITY	16,827	7,824	1,793	10,341	1,987	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,997	194	292	0	266	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,658	356	260	0	342	54.00
60.00	LABORATORY	2,682	0	297	0	560	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	2,764	190	306	0	334	66.00
67.00	OCCUPATIONAL THERAPY	944	0	104	0	104	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	923	0	86	0	156	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	9,905	142	736	0	931	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	2,387	736	264	0	807	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	5,380	50	0	0	220	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	79,310	12,003	6,471	16,132	8,466	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	28	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	79,310	12,003	6,471	16,160	8,466	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBRA	SOCIAL SERVICE	
		13.00	14.00	16.00	16.01	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	PURCHASING						5.01
5.02	PERSONNEL						5.02
5.03	HOSPITAL BILLING						5.03
5.04	NURSING HOME BILLING						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	8,090					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	6,827				14.00
16.00	MEDICAL RECORDS & LIBRARY	0	269	15,505			16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	0	0	0	943		16.01
17.00	SOCIAL SERVICE	147	4	0	0	1,974	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,269	965	1,896	0	1,306	30.00
44.00	SKILLED NURSING FACILITY	0	807	0	943	668	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	441	723	810	0	0	50.00
53.00	ANESTHESIOLOGY	0	57	173	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	370	2,075	0	0	54.00
60.00	LABORATORY	0	692	2,117	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	249	0	0	65.00
66.00	PHYSICAL THERAPY	553	225	1,446	0	0	66.00
67.00	OCCUPATIONAL THERAPY	173	0	632	0	0	67.00
68.00	SPEECH PATHOLOGY	1	0	12	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	116	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	34	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	79	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	259	106	2,034	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,543	956	2,627	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,339	961	692	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	365	692	513	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,090	6,827	15,505	943	1,974	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	8,090	6,827	15,505	943	1,974	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.01	PURCHASING					5.01
5.02	PERSONNEL					5.02
5.03	HOSPITAL BILLING					5.03
5.04	NURSING HOME BILLING					5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA					16.01
17.00	SOCIAL SERVICE					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	158,472	0	158,472		30.00
44.00	SKILLED NURSING FACILITY	110,371	0	110,371		44.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	116,394	0	116,394		50.00
53.00	ANESTHESIOLOGY	659	0	659		53.00
54.00	RADIOLOGY-DIAGNOSTIC	69,249	0	69,249		54.00
60.00	LABORATORY	58,104	0	58,104		60.00
65.00	RESPIRATORY THERAPY	583	0	583		65.00
66.00	PHYSICAL THERAPY	20,290	0	20,290		66.00
67.00	OCCUPATIONAL THERAPY	6,677	0	6,677		67.00
68.00	SPEECH PATHOLOGY	33	0	33		68.00
69.00	ELECTROCARDIOLOGY	928	0	928		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	148	0	148		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	209	0	209		72.00
73.00	DRUGS CHARGED TO PATIENTS	18,686	0	18,686		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	68,290	0	68,290		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	33,882	0	33,882		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	51,480	0	51,480		95.00
99.10	CORF	0	0	0		99.10
	SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0		111.00
113.00	INTEREST EXPENSE	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	714,455	0	714,455		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	RENTAL HOUSE	0	0	0		194.00
194.01	RENTAL SPACE	0	0	0		194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	28	0	28		194.02
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	714,483	0	714,483		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	PURCHASING (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
		1.00	2.00	4.00	5.01	5.02	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	58,087					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		312,061				2.00
4.00	EMPLOYEE BENEFITS	0	0	5,344,382			4.00
5.01	PURCHASING	1,692	0	31,148	2,404		5.01
5.02	PERSONNEL	538	673	103,410	40	5,209,824	5.02
5.03	HOSPITAL BILLING	929	4,188	227,453	67	227,453	5.03
5.04	NURSING HOME BILLING	94	0	150	0	150	5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	2,803	20,556	342,213	127	342,213	5.05
7.00	OPERATION OF PLANT	10,460	4,051	138,304	62	138,304	7.00
8.00	LAUNDRY & LINEN SERVICE	1,332	0	0	1	0	8.00
9.00	HOUSEKEEPING	556	0	166,296	67	166,296	9.00
10.00	DIETARY	1,541	643	189,087	61	189,087	10.00
11.00	CAFETERIA	593	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	787	0	105,252	35	105,252	13.00
14.00	CENTRAL SERVICES & SUPPLY	520	0	15,904	395	15,904	14.00
16.00	MEDICAL RECORDS & LIBRARY	1,224	2,402	166,770	61	166,770	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	100	0	3,972	0	3,972	16.01
17.00	SOCIAL SERVICE	153	0	54,603	1	54,603	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,360	49,440	949,729	219	949,729	30.00
44.00	SKILLED NURSING FACILITY	8,820	1,719	690,484	183	690,484	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,095	91,449	125,063	164	125,063	50.00
53.00	ANESTHESIOLOGY	0	0	0	13	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,393	49,571	189,174	84	189,174	54.00
60.00	LABORATORY	1,406	36,409	295,324	157	295,324	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	1,449	1,362	252,204	51	252,204	66.00
67.00	OCCUPATIONAL THERAPY	495	0	118,319	0	118,319	67.00
68.00	SPEECH PATHOLOGY	0	0	556	0	556	68.00
69.00	ELECTROCARDIOLOGY	0	688	3,668	0	3,668	69.00
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	484	7,799	119,697	24	119,697	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	5,192	6,151	609,253	217	609,253	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,251	12,448	345,589	218	345,589	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	2,820	22,512	100,760	157	100,760	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	58,087	312,061	5,344,382	2,404	5,209,824	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	401,133	313,350	1,200,750	55,196	158,499	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.905728	1.004131	0.224675	22.960067	0.030423	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	11,684	4,585	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	4.860233	0.000880	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	HOSPITAL BILLING (NON-NURSING HOME CHARGES)	NURSING HOME BILLING (NURSING HOME CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	7.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	PURCHASING						5.01
5.02	PERSONNEL						5.02
5.03	HOSPITAL BILLING	11,574,492					5.03
5.04	NURSING HOME BILLING	0	1,738,331				5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL	0	0	-1,260,695	9,593,871		5.05
7.00	OPERATION OF PLANT	0	0	0	606,384	41,571	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	60,780	1,332	8.00
9.00	HOUSEKEEPING	0	0	0	257,348	556	9.00
10.00	DIETARY	0	0	0	336,390	1,541	10.00
11.00	CAFETERIA	0	0	0	4,095	593	11.00
13.00	NURSING ADMINISTRATION	0	0	0	143,880	787	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	38,391	520	14.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	239,628	1,224	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	0	0	0	6,102	100	16.01
17.00	SOCIAL SERVICE	0	0	0	70,289	153	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,415,247	0	0	1,557,412	9,360	30.00
44.00	SKILLED NURSING FACILITY	0	1,738,331	0	1,031,686	8,820	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	604,248	0	0	442,400	2,095	50.00
53.00	ANESTHESIOLOGY	128,972	0	0	56,728	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,548,686	0	0	404,812	1,393	54.00
60.00	LABORATORY	1,580,110	0	0	690,122	1,406	60.00
65.00	RESPIRATORY THERAPY	186,030	0	0	36,441	0	65.00
66.00	PHYSICAL THERAPY	1,078,762	0	0	372,534	1,449	66.00
67.00	OCCUPATIONAL THERAPY	471,864	0	0	174,419	495	67.00
68.00	SPEECH PATHOLOGY	9,063	0	0	2,540	0	68.00
69.00	ELECTROCARDIOLOGY	86,578	0	0	8,115	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,665	0	0	20,960	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	58,848	0	0	17,071	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,517,666	0	0	531,171	484	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,962,959	0	0	1,392,544	5,192	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	516,731	0	0	866,488	1,251	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	383,063	0	0	225,141	2,820	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,574,492	1,738,331	-1,260,695	9,593,871	41,571	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	411,523	925		1,260,695	686,066	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.035554	0.000532		0.131406	16.503476	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	11,146	649		40,916	79,310	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000963	0.000373		0.004265	1.907820	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (COSTED REQUIS.)	
		8.00	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
5.01	PURCHASING						5.01
5.02	PERSONNEL						5.02
5.03	HOSPITAL BILLING						5.03
5.04	NURSING HOME BILLING						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE	29,019					8.00
9.00	HOUSEKEEPING	0	30,654				9.00
10.00	DIETARY	0	165	47,503			10.00
11.00	CAFETERIA	0	0	9,473	9,562		11.00
13.00	NURSING ADMINISTRATION	0	358	0	227	114,553	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	520	0	39	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	0	557	0	512	0	16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	0	100	0	12	0	16.01
17.00	SOCIAL SERVICE	0	153	0	100	2,087	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,070	9,199	7,549	2,225	46,277	30.00
44.00	SKILLED NURSING FACILITY	18,915	8,492	30,399	2,246	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	468	1,383	0	300	6,250	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	861	1,233	0	386	0	54.00
60.00	LABORATORY	0	1,406	0	633	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	459	1,449	0	377	7,835	66.00
67.00	OCCUPATIONAL THERAPY	0	495	0	118	2,452	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	10	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	406	0	176	3,661	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	344	3,487	0	1,051	21,851	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,780	1,251	0	912	18,967	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	122	0	0	248	5,163	95.00
99.10	CORF	0	0	0	0	0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,019	30,654	47,421	9,562	114,553	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	RENTAL HOUSE	0	0	0	0	0	194.00
194.01	RENTAL SPACE	0	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	82	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	90,750	300,341	407,643	95,712	181,555	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.127261	9.797775	8.581416	10.009621	1.584900	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	12,003	6,471	16,160	8,466	8,090	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.413626	0.211098	0.340189	0.885380	0.070622	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	CENTRAL SERVICES & SUPPLY (PURCHASE ORDERS)	MEDICAL RECORDS & LIBRARY (NON-NURSING HOME CHARGES)	NURSING HOME MEDICAL RECORDS & LIBRA (NURSING HOME CHARGES)	SOCIAL SERVICE (TIME SPENT)		
		14.00	16.00	16.01	17.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	PURCHASING						5.01
5.02	PERSONNEL						5.02
5.03	HOSPITAL BILLING						5.03
5.04	NURSING HOME BILLING						5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY	1,549					14.00
16.00	MEDICAL RECORDS & LIBRARY	61	11,574,492				16.00
16.01	NURSING HOME MEDICAL RECORDS & LIBRA	0	0	1,738,331			16.01
17.00	SOCIAL SERVICE	1	0	0	316		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	219	1,415,247	0	209		30.00
44.00	SKILLED NURSING FACILITY	183	0	1,738,331	107		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	164	604,248	0	0		50.00
53.00	ANESTHESIOLOGY	13	128,972	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	84	1,548,686	0	0		54.00
60.00	LABORATORY	157	1,580,110	0	0		60.00
65.00	RESPIRATORY THERAPY	0	186,030	0	0		65.00
66.00	PHYSICAL THERAPY	51	1,078,762	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	471,864	0	0		67.00
68.00	SPEECH PATHOLOGY	0	9,063	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	86,578	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,665	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	58,848	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	24	1,517,666	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	217	1,962,959	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	CLINIC	0	0	0	0		90.00
91.00	EMERGENCY	218	516,731	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	157	383,063	0	0		95.00
99.10	CORF	0	0	0	0		99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0	0		111.00
113.00	INTEREST EXPENSE	0	0	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,549	11,574,492	1,738,331	316		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	RENTAL HOUSE	0	0	0	0		194.00
194.01	RENTAL SPACE	0	0	0	0		194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	57,503	304,163	9,654	87,895		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	37.122660	0.026279	0.005554	278.148734		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	6,827	15,505	943	1,974		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.407360	0.001340	0.000542	6.246835		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 12/19/2011 9:46 am

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	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,289,498		2,289,498	0	2,289,498	30.00
44.00	SKILLED NURSING FACILITY	1,784,728		1,784,728	0	1,784,728	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	584,999		584,999	0	584,999	50.00
53.00	ANESTHESIOLOGY	68,054		68,054	0	68,054	53.00
54.00	RADIOLOGY-DIAGNOSTIC	543,450		543,450	0	543,450	54.00
60.00	LABORATORY	871,476		871,476	0	871,476	60.00
65.00	RESPIRATORY THERAPY	46,119	0	46,119	0	46,119	65.00
66.00	PHYSICAL THERAPY	507,467	0	507,467	0	507,467	66.00
67.00	OCCUPATIONAL THERAPY	227,825	0	227,825	0	227,825	67.00
68.00	SPEECH PATHOLOGY	3,128	0	3,128	0	3,128	68.00
69.00	ELECTROCARDIOLOGY	11,456		11,456	0	11,456	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,388		24,388	0	24,388	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	20,860		20,860	0	20,860	72.00
73.00	DRUGS CHARGED TO PATIENTS	661,274		661,274	0	661,274	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,801,250		1,801,250	0	1,801,250	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	0		0	0	0	90.00
91.00	EMERGENCY	1,079,682		1,079,682	0	1,079,682	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	68,925		68,925		68,925	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	328,208		328,208	0	328,208	95.00
99.10	CORF	0		0		0	99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0		0		0	109.00
110.00	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	ISLET ACQUISITION	0		0		0	111.00
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	10,922,787	0	10,922,787	0	10,922,787	200.00
201.00	Less Observation Beds	68,925		68,925		68,925	201.00
202.00	Total (see instructions)	10,853,862	0	10,853,862	0	10,853,862	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 12/19/2011 9:46 am

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	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,247,276		1,247,276			30.00
44.00	SKILLED NURSING FACILITY	1,738,331		1,738,331			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	604,248	604,248	0.968144	0.000000	50.00
53.00	ANESTHESIOLOGY	0	128,972	128,972	0.527665	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	71,037	1,477,649	1,548,686	0.350910	0.000000	54.00
60.00	LABORATORY	188,222	1,391,888	1,580,110	0.551529	0.000000	60.00
65.00	RESPIRATORY THERAPY	115,106	70,925	186,031	0.247910	0.000000	65.00
66.00	PHYSICAL THERAPY	548,006	530,756	1,078,762	0.470416	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	365,710	111,054	476,764	0.477857	0.000000	67.00
68.00	SPEECH PATHOLOGY	3,165	998	4,163	0.751381	0.000000	68.00
69.00	ELECTROCARDIOLOGY	5,773	80,805	86,578	0.132320	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,542	23,123	25,665	0.950244	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	58,848	58,848	0.354473	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	629,106	888,560	1,517,666	0.435718	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	17,491	1,945,468	1,962,959			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	784	515,947	516,731	2.089447	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	167,971	167,971	0.410339	0.000000	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	383,063	383,063	0.856799	0.000000	95.00
99.10	CORF	0	0	0			99.10
	SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	4,932,549	8,380,275	13,312,824			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	4,932,549	8,380,275	13,312,824			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 12/19/2011 9:46 am

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	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
44.00	SKILLED NURSING FACILITY			44.00
	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
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO 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
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	0.000000		95.00
99.10	CORF			99.10
	SPECIAL PURPOSE COST CENTERS			
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
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: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part II Date/Time Prepared: 12/19/2011 9:46 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	116,394	604,248	0.192626	0	0	50.00
53.00	ANESTHESIOLOGY	659	128,972	0.005110	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	69,249	1,548,686	0.044715	28,944	1,294	54.00
60.00	LABORATORY	58,104	1,580,110	0.036772	64,195	2,361	60.00
65.00	RESPIRATORY THERAPY	583	186,031	0.003134	41,902	131	65.00
66.00	PHYSICAL THERAPY	20,290	1,078,762	0.018809	4,801	90	66.00
67.00	OCCUPATIONAL THERAPY	6,677	476,764	0.014005	3,489	49	67.00
68.00	SPEECH PATHOLOGY	33	4,163	0.007927	0	0	68.00
69.00	ELECTROCARDIOLOGY	928	86,578	0.010719	2,023	22	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	148	25,665	0.005767	181	1	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	209	58,848	0.003552	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	18,686	1,517,666	0.012312	153,297	1,887	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	68,290	1,962,959	0.034789	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	33,882	516,731	0.065570	41	3	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	167,971	0.000000	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	394,132	9,944,154		298,873	5,838	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 12/19/2011 9:46 am

Title XVIII | Hospital | Cost

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO 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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 12/19/2011 9:46 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	604,248	0.000000	0.000000	0	50.00
53.00	ANESTHESIOLOGY	0	128,972	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,548,686	0.000000	0.000000	28,944	54.00
60.00	LABORATORY	0	1,580,110	0.000000	0.000000	64,195	60.00
65.00	RESPIRATORY THERAPY	0	186,031	0.000000	0.000000	41,902	65.00
66.00	PHYSICAL THERAPY	0	1,078,762	0.000000	0.000000	4,801	66.00
67.00	OCCUPATIONAL THERAPY	0	476,764	0.000000	0.000000	3,489	67.00
68.00	SPEECH PATHOLOGY	0	4,163	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	86,578	0.000000	0.000000	2,023	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,665	0.000000	0.000000	181	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	58,848	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,517,666	0.000000	0.000000	153,297	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,962,959	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	516,731	0.000000	0.000000	41	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	167,971	0.000000	0.000000	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	9,944,154			298,873	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 12/19/2011 9:46 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO 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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 12/19/2011 9:46 am

Title XVIII | Hospital | Cost

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 12/19/2011 9:46 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	0.968144	0	313,347	0		50.00
53.00	ANESTHESIOLOGY	0.527665	0	67,200	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.350910	0	374,529	0		54.00
60.00	LABORATORY	0.551529	0	443,637	0		60.00
65.00	RESPIRATORY THERAPY	0.247910	0	44,397	0		65.00
66.00	PHYSICAL THERAPY	0.470416	0	261,218	0		66.00
67.00	OCCUPATIONAL THERAPY	0.477857	0	89,615	0		67.00
68.00	SPEECH PATHOLOGY	0.751381	0	971	0		68.00
69.00	ELECTROCARDIOLOGY	0.132320	0	30,207	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.950244	0	1,851	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.354473	0	43,245	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.435718	0	351,117	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	0.000000	0	0	0		90.00
91.00	EMERGENCY	2.089447	0	144,358	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.410339	0	81,670	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.856799		0			95.00
200.00	Subtotal (see instructions)		0	2,247,362	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	2,247,362	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 12/19/2011 9:46 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	303,365	0		50.00
53.00	ANESTHESIOLOGY	0	35,459	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	131,426	0		54.00
60.00	LABORATORY	0	244,679	0		60.00
65.00	RESPIRATORY THERAPY	0	11,006	0		65.00
66.00	PHYSICAL THERAPY	0	122,881	0		66.00
67.00	OCCUPATIONAL THERAPY	0	42,823	0		67.00
68.00	SPEECH PATHOLOGY	0	730	0		68.00
69.00	ELECTROCARDIOLOGY	0	3,997	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,759	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	15,329	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	152,988	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	301,628	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	33,512	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	1,401,582	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	1,401,582	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 12/19/2011 9:46 am

Component CCN: 14Z329 | 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	0.968144	0	0	0		50.00
53.00	ANESTHESIOLOGY	0.527665	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.350910	0	0	0		54.00
60.00	LABORATORY	0.551529	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0.247910	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.470416	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0.477857	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0.751381	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0.132320	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.950244	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.354473	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.435718	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	0.000000	0	0	0		90.00
91.00	EMERGENCY	2.089447	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.410339	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.856799		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: 141329 | Component CCN: 14Z329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 12/19/2011 9:46 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
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO 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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
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 INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/19/2011 9:46 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO 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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/19/2011 9:46 am
	Title XVIII	Skilled Nursing Facility	PPS

	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	604,248	0.000000	0.000000	0	50.00
53.00	ANESTHESIOLOGY	0	128,972	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,548,686	0.000000	0.000000	0	54.00
60.00	LABORATORY	0	1,580,110	0.000000	0.000000	0	60.00
65.00	RESPIRATORY THERAPY	0	186,031	0.000000	0.000000	0	65.00
66.00	PHYSICAL THERAPY	0	1,078,762	0.000000	0.000000	0	66.00
67.00	OCCUPATIONAL THERAPY	0	476,764	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	4,163	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	86,578	0.000000	0.000000	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,665	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	58,848	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,517,666	0.000000	0.000000	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,962,959	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	516,731	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	167,971	0.000000	0.000000	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	9,944,154			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 Component CCN: 145274 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 12/19/2011 9:46 am

Title XVIII | Skilled Nursing Facility | PPS

	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO 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
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/19/2011 9:46 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/19/2011 9:46 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)	2,571	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	504	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)	504	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	963	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)	899	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	119	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)	86	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	234	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)	904	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)	899	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	119.75	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	119.75	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,289,498	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)	14,250	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)	10,298	25.00
26.00	Total swing-bed cost (see instructions)	1,807,022	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	482,476	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	385,007	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.253162	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)	0.00	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)	482,476	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)	957.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	224,006	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)	224,006	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 12/19/2011 9:46 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	127,195	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	351,201	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)	865,390	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	860,604	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,725,994	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)	72	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	957.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	68,925	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 12/19/2011 9:46 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: 141329	Period: From 07/01/2010	Worksheet D-1
	Component CCN: 145274	To 06/30/2011	Date/Time Prepared: 12/19/2011 9:46 am
	Title XVIII	Skilled Nursing Facility	PPS

	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)	10,504	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,504	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)	10,504	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	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	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,784,728	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,784,728	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,738,331	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.026691	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)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,784,728	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 12/19/2011 9:46 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	1,784,728	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	169.91	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/19/2011 9:46 am
	Title XVIII	Skilled Nursing Facility	PPS

	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: 141329 Component CCN: 145274	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/19/2011 9:46 am
	Title XIX	Skilled Nursing Facility	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)	10,504	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,504	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)	10,504	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,376	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	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	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)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,738,331	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	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)	0.00	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)	0	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 12/19/2011 9:46 am

Title XIX | Skilled Nursing Facility | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	0	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0.00	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	110,371	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	10.51	76.00
77.00	Program capital-related costs (line 9 x line 76)	67,012	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	-67,012	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	-67,012	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/19/2011 9:46 am
	Title XIX	Skilled Nursing Facility	Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 12/19/2011 9:46 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		212,553		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.968144	0	0	50.00
53.00	ANESTHESIOLOGY	0.527665	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.350910	28,944	10,157	54.00
60.00	LABORATORY	0.551529	64,195	35,405	60.00
65.00	RESPIRATORY THERAPY	0.247910	41,902	10,388	65.00
66.00	PHYSICAL THERAPY	0.470416	4,801	2,258	66.00
67.00	OCCUPATIONAL THERAPY	0.477857	3,489	1,667	67.00
68.00	SPEECH PATHOLOGY	0.751381	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.132320	2,023	268	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.950244	181	172	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.354473	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.435718	153,297	66,794	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	2.089447	41	86	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.410339	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		298,873	127,195	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)		298,873		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 12/19/2011 9:46 am

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.968144	0	0	50.00
53.00	ANESTHESIOLOGY	0.527665	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.350910	21,401	7,510	54.00
60.00	LABORATORY	0.551529	71,044	39,183	60.00
65.00	RESPIRATORY THERAPY	0.247910	40,317	9,995	65.00
66.00	PHYSICAL THERAPY	0.470416	517,055	243,231	66.00
67.00	OCCUPATIONAL THERAPY	0.477857	343,896	164,333	67.00
68.00	SPEECH PATHOLOGY	0.751381	3,120	2,344	68.00
69.00	ELECTROCARDIOLOGY	0.132320	2,737	362	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.950244	2,179	2,071	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.354473	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.435718	360,437	157,049	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	2.089447	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.410339	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,362,186	626,078	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,362,186		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/19/2011 9:46 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,401,582	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)	1,401,582	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)	1,415,598	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)	12,728	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	359,649	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,043,221	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,043,221	30.00
31.00	Primary payer payments	214	31.00
32.00	Subtotal (line 30 minus line 31)	1,043,007	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)	37,079	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	37,079	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,463	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,080,086	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	1,080,086	40.00
41.00	Interim payments	1,094,960	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)	-14,874	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/19/2011 9:46 am
	Title XVIII	Hospital	Cost

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I Date/Time Prepared: 12/19/2011 9:46 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		263,419		1,166,822	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/25/2011	1,893	02/25/2011	102,872	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/20/2011	896	05/20/2011	174,734	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)		997		-71,862	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)		264,416		1,094,960	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		41,361		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		14,874	6.02
7.00	Total Medicare program liability (see instructions)		305,777		1,080,086	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 12/19/2011 9:46 am

Component CCN: 14Z329 | 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		2,042,833		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/25/2011	68,839		0	3.01
3.02		05/20/2011	53,537		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)		122,376		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)		2,165,209		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		166,864		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,332,073		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: 141329 Component CCN: 14Z329	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2 Date/Time Prepared: 12/19/2011 9:46 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)	1,743,254	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)	632,339	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	1,803	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)	2,375,593	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,375,593	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)	2,375,593	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	45,995	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)	2,329,598	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	2,475	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	2,475	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	2,332,073	0	19.00
20.00	Interim payments	2,165,209	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)	166,864	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: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 12/19/2011 9:46 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	351,201	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)	351,201	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)	354,713	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)	354,713	19.00
20.00	Deductibles (exclude professional component)	58,733	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)	295,980	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	295,980	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,797	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	9,797	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9,797	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))	305,777	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)	305,777	30.00
31.00	Interim payments	264,416	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)	41,361	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VI Date/Time Prepared: 12/19/2011 9:46 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	0	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	0	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	0	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	0	15.00
16.00	Interim payments	0	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G | Date/Time Prepared: 12/19/2011 9:46 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	895,143	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,605,949	0	0	0	4.00
5.00	Other receivable	967,758	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	151,076	0	0	0	7.00
8.00	Prepaid expenses	87,358	0	0	0	8.00
9.00	Other current assets	149,000	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)	3,856,284	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	21,657	0	0	0	12.00
13.00	Land improvements	492,947	0	0	0	13.00
14.00	Accumulated depreciation	-228,969	0	0	0	14.00
15.00	Buildings	7,641,389	0	0	0	15.00
16.00	Accumulated depreciation	-4,122,181	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	328,274	0	0	0	19.00
20.00	Accumulated depreciation	-323,827	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	3,640,724	0	0	0	23.00
24.00	Accumulated depreciation	-2,418,075	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)	5,031,939	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	510,407	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	510,407	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,398,630	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	288,297	0	0	0	37.00
38.00	Salaries, wages, and fees payable	345,191	0	0	0	38.00
39.00	Payroll taxes payable	78,532	0	0	0	39.00
40.00	Notes and loans payable (short term)	205,436	0	0	0	40.00
41.00	Deferred income	431,500	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,348,956	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,426,321	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,426,321	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,775,277	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,623,353				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)	4,623,353	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,398,630	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 12/19/2011 9:46 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		4,861,145		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-237,792				2.00
3.00	Total (sum of line 1 and line 2)		4,623,353		0		3.00
4.00		0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,623,353		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)		4,623,353		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 12/19/2011 9:46 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		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: 141329 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 12/19/2011 9:46 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	385,007		385,007	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	864,179		864,179	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,738,331		1,738,331	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,987,517		2,987,517	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,987,517		2,987,517	17.00
18.00	Ancillary services	1,947,638	5,452,246	7,399,884	18.00
19.00	Outpatient services	1,066	939,814	940,880	19.00
20.00	RURAL HEALTH CLINIC	0	2,034,662	2,034,662	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	385,012	385,012	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,936,221	8,811,734	13,747,955	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		11,269,097		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		11,269,097		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141329	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 12/19/2011 9:46 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	13,747,955	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,954,571	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,793,384	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	11,269,097	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-475,713	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	44,187	6.00
7.00	Income from investments	13,210	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	22,939	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	4,514	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	107,078	24.00
24.01	COUNTY TAX REVENUE	822,821	24.01
24.02	STATE TAX REVENUE	91,051	24.02
25.00	Total other income (sum of lines 6-24)	1,105,800	25.00
26.00	Total (line 5 plus line 25)	630,087	26.00
27.00	BAD DEBTS	806,011	27.00
27.01	CHARITY CARE	61,868	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	867,879	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-237,792	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 12/19/2011 9:46 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	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	609,253	0	609,253	0	609,253	9.00
10.00	Subtotal (sum of lines 1-9)	609,253	0	609,253	0	609,253	10.00
11.00	Physician Services Under Agreement	0	488,195	488,195	0	488,195	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	51,665	51,665	0	51,665	13.00
14.00	Subtotal (sum of lines 11-13)	0	539,860	539,860	0	539,860	14.00
15.00	Medical Supplies	0	20,201	20,201	-392	19,809	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	110,398	110,398	0	110,398	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	130,599	130,599	-392	130,207	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	609,253	670,459	1,279,712	-392	1,279,320	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	13,891	13,891	0	13,891	29.00
30.00	Administrative Costs	0	32,761	32,761	-110,398	-77,637	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	46,652	46,652	-110,398	-63,746	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	609,253	717,111	1,326,364	-110,790	1,215,574	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 12/19/2011 9:46 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	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	-52,532	556,721		9.00
10.00	Subtotal (sum of lines 1-9)	-52,532	556,721		10.00
11.00	Physician Services Under Agreement	0	488,195		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	51,665		13.00
14.00	Subtotal (sum of lines 11-13)	0	539,860		14.00
15.00	Medical Supplies	0	19,809		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	110,398		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	130,207		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-52,532	1,226,788		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	13,891		29.00
30.00	Administrative Costs	-42,727	-120,364		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-42,727	-106,473		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-95,259	1,120,315		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-2 | Date/Time Prepared: 12/19/2011 9:46 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	2.83	13,834	4,200	11,886		1.00
2.00	Physician Assistant	0.72	4,273	2,100	1,512		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	3.55	18,107		13,398	18,107	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)	3.55	18,107			18,107	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,226,788	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,226,788	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)					-106,473	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					680,935	15.00
16.00	Total overhead (sum of lines 14 and 15)					574,462	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					574,462	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					574,462	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,801,250	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 12/19/2011 9:46 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)	1,801,250	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)	2,562	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,798,688	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)	18,107	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)	18,107	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	99.34	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)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	99.34	99.34	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	877	877	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	87,121	87,121	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) *	87,121	87,121	16.00
16.01	Total program charges (see instructions)(from contractor's records)		102,200	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		19,121	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		16,300	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		36,466	16.04
16.05	Total program cost (see instructions)	69,697	52,766	16.05
17.00	Primary payer amounts		49	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,238	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		35,833	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		122,414	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		283	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		122,697	22.00
23.00	Reimbursable bad debts (see instructions)		3,430	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		2,693	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)		126,127	26.00
27.00	Interim payments		101,719	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)		24,408	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141329 Component CCN:143981	Period: From 07/01/2010 To 06/30/2011	Worksheet M-4 Date/Time Prepared: 12/19/2011 9:46 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	556,721	556,721	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000238	0.000314	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	132	175	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,050	388	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,182	563	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,226,788	1,226,788	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	574,462	574,462	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000963	0.000459	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	553	264	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,735	827	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	25	33	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	69.40	25.06	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	3	3	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	208	75	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		2,562	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		283	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 12/19/2011 9:46 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		94,042	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		02/25/2011	7,677	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		7,677	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		101,719	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		24,408	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		126,127	7.00

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