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: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 1/20/2012 10:11 am

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 1/20/2012 Time: 10:11 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAWRENCE COUNTY MEMORIAL 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	31,197	-99,689	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	24,531	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		-30,953		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	55,728	-130,642	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: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/18/2012 10:36 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2100 STATE STREET	PO Box: 62439			1.00
2.00	City: LAWRENCEVILLE	State: IL	Zip Code: 62439-	County: LAWRENCE	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	LAWRENCE COUNTY MEMORIAL HOSPITAL	141344	14	1	04/01/2005	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	LAWRENCE COUNTY MEMORIAL HOSPITAL	14Z344	14		04/01/2005	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	LCMH PRIMARY CARE CLINIC	143499	14		03/26/2009	N	O	N	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)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

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

		Beginning:	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/18/2012 10:36 am

		Beginning:	Ending:	
		1.00	2.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 1/18/2012 10:36 am

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	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: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/18/2012 10:36 am

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	Y	Y	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.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/18/2012 10:36 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/18/2012 10:36 am

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

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

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

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	10/04/2011	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/18/2012 10:36 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II Date/Time Prepared: 1/18/2012 10:36 am

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/04/2011	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/18/2012 10:36 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	60,792.00		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	60,792.00		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	60,792.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	40.00	0	0			16.00
17.00	SUBPROVIDER - IRF	41.00	0	0			17.00
18.00	SUBPROVIDER	42.00	0	0			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	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)		25				27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF	40.00					28.01
28.02	SUBPROVIDER - IRF	41.00					28.02
28.03	SUBPROVIDER	42.00					28.03
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: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,975	232	2,485		1.00
2.00	HMO		12	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	627	0	627		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	19		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,602	232	3,131		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	2,602	232	3,131		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	0	0	0		16.00
17.00	SUBPROVIDER - IRF	0	0	0	0		17.00
18.00	SUBPROVIDER	0	0	0	0		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	0	0	0	0		25.10
26.00	RURAL HEALTH CLINIC	0	2,846	3,983	10,021		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		4	14		28.00
28.01	SUBPROVIDER - IPF	0	0	0	0		28.01
28.02	SUBPROVIDER - IRF	0	0	0	0		28.02
28.03	SUBPROVIDER	0	0	0	0		28.03
29.00	Ambulance Trips		467				29.00
30.00	Employee discount days (see instruction)				17		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: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/18/2012 10:36 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	550	1.00
2.00	HMO					3	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	127.18	0.00	0	550	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0.00	0.00	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00	SUBPROVIDER	0.00	0.00	0.00	0	0	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	0.00	0.00	0.00			25.10
26.00	RURAL HEALTH CLINIC	0.00	10.72	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	137.90	0.00			27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF						28.01
28.02	SUBPROVIDER - IRF						28.02
28.03	SUBPROVIDER						28.03
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: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/18/2012 10:36 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)	103	894		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)	103	894		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF	0	0		16.00
17.00	SUBPROVIDER - IRF	0	0		17.00
18.00	SUBPROVIDER	0	0		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
28.01	SUBPROVIDER - IPF				28.01
28.02	SUBPROVIDER - IRF				28.02
28.03	SUBPROVIDER				28.03
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-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 141344 Component CCN: 143499 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-8 | Date/Time Prepared: 1/18/2012 10:36 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	2111 LEXINGTON AVENUE	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	LAWRENCEVILLE IL	62439 2.00
		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00
		Grant Award	Date
		1.00	2.00
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
9.01		0	9.01
9.02		0	9.02
9.03		0	9.03
9.04		0	9.04
9.05		0	9.05
9.06		0	9.06
9.07		0	9.07
9.08		0	9.08
9.09		0	9.09
9.10		0	9.10
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic			08:00	17:00	11.00

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

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

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/18/2012 10:36 am
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/18/2012 10:36 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	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/18/2012 10:36 am
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/18/2012 10:36 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)	0.467433	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,417,784	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	636,666	5.00
6.00	Medicaid charges	6,567,336	6.00
7.00	Medicaid cost (line 1 times line 6)	3,069,790	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,015,340	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,015,340	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	398,603	393,050	791,653	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	186,320	183,725	370,045	21.00
22.00	Partial payment by patients approved for charity care	16,505	289,246	305,751	22.00
23.00	Cost of charity care (line 21 minus line 22)	169,815	-105,521	64,294	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)	1,251,919	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	333,149	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	918,770	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	429,463	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	493,757	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,509,097	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/18/2012 10:36 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		265,377	265,377	0	265,377	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		366,416	366,416	0	366,416	2.00
4.00	EMPLOYEE BENEFITS	0	1,626,649	1,626,649	30,497	1,657,146	4.00
5.01	ADMINISTRATIVE & GENERAL	282,216	294,615	576,831	0	576,831	5.01
5.02	PURCHASING, RECEIVING AND STORES	59,625	7,436	67,061	0	67,061	5.02
5.03	COMMUNICATIONS	0	53,807	53,807	0	53,807	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	216,696	975,098	1,191,794	-30,497	1,161,297	5.04
6.00	MAINTENANCE & REPAIRS	143,905	95,127	239,032	0	239,032	6.00
7.00	OPERATION OF PLANT	0	106,015	106,015	0	106,015	7.00
8.00	LAUNDRY & LINEN SERVICE	0	51,067	51,067	0	51,067	8.00
9.00	HOUSEKEEPING	161,173	22,677	183,850	0	183,850	9.00
10.00	DIETARY	195,535	157,035	352,570	-258,897	93,673	10.00
11.00	CAFETERIA	0	0	0	258,897	258,897	11.00
13.00	NURSING ADMINISTRATION	130,373	22,488	152,861	0	152,861	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	156,618	22,248	178,866	0	178,866	15.00
16.00	MEDICAL RECORDS & LIBRARY	195,564	57,211	252,775	0	252,775	16.00
17.00	SOCIAL SERVICE	54,029	629	54,658	0	54,658	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	662	662	0	662	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	826,541	70,700	897,241	0	897,241	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	173,400	139,390	312,790	0	312,790	50.00
53.00	ANESTHESIOLOGY	15,290	289,543	304,833	0	304,833	53.00
54.00	RADIOLOGY-DIAGNOSTIC	208,330	705,601	913,931	0	913,931	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	422,265	384,492	806,757	0	806,757	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	54,313	54,313	0	54,313	62.00
65.00	RESPIRATORY THERAPY	145,133	24,667	169,800	0	169,800	65.00
66.00	PHYSICAL THERAPY	108,601	11,910	120,511	0	120,511	66.00
66.01	CARDIAC REHAB	48,875	1,058	49,933	0	49,933	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	59,663	59,663	0	59,663	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	150,420	150,420	0	150,420	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	367	7,387	7,754	0	7,754	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	379,622	504,458	884,080	11,312	895,392	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	57,953	307,900	365,853	0	365,853	90.00
91.00	EMERGENCY	362,316	943,650	1,305,966	0	1,305,966	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	170,027	43,900	213,927	0	213,927	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,514,454	7,823,609	12,338,063	11,312	12,349,375	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	31,126	31,126	-11,312	19,814	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	TOTAL (SUM OF LINES 118-199)	4,514,454	7,854,735	12,369,189	0	12,369,189	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	265,377		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-4,617	361,799		2.00
4.00	EMPLOYEE BENEFITS	-567	1,656,579		4.00
5.01	ADMINISTRATIVE & GENERAL	-26,022	550,809		5.01
5.02	PURCHASING, RECEIVING AND STORES	-21,740	45,321		5.02
5.03	COMMUNICATIONS	0	53,807		5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-60,000	1,101,297		5.04
6.00	MAINTENANCE & REPAIRS	0	239,032		6.00
7.00	OPERATION OF PLANT	0	106,015		7.00
8.00	LAUNDRY & LINEN SERVICE	0	51,067		8.00
9.00	HOUSEKEEPING	0	183,850		9.00
10.00	DIETARY	0	93,673		10.00
11.00	CAFETERIA	-75,710	183,187		11.00
13.00	NURSING ADMINISTRATION	0	152,861		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	PHARMACY	0	178,866		15.00
16.00	MEDICAL RECORDS & LIBRARY	-5,242	247,533		16.00
17.00	SOCIAL SERVICE	0	54,658		17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	662		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	897,241		30.00
40.00	SUBPROVIDER - IPF	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0		41.00
42.00	SUBPROVIDER	0	0		42.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	312,790		50.00
53.00	ANESTHESIOLOGY	-259,605	45,228		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	913,931		54.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0		59.00
60.00	LABORATORY	0	806,757		60.00
60.01	BLOOD LABORATORY	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	54,313		62.00
65.00	RESPIRATORY THERAPY	0	169,800		65.00
66.00	PHYSICAL THERAPY	0	120,511		66.00
66.01	CARDIAC REHAB	-185	49,748		66.01
69.00	ELECTROCARDIOLOGY	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	59,663		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	150,420		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	7,754		76.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-47,903	847,489		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	-279,909	85,944		90.00
91.00	EMERGENCY	-186,127	1,119,839		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	FAMILY PRACTICE	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	213,927		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
118.00	SUBTOTALS (SUM OF LINES 1-117)	-967,627	11,381,748		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	19,814		192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0		192.01
192.02	LSC	0	0		192.02
192.03	PUBLIC RELATIONS	0	0		192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
200.00	TOTAL (SUM OF LINES 118-199)	-967,627	11,401,562		200.00

RECLASSIFICATIONS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/18/2012 10:36 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	143,584	115,313		1.00
	TOTALS		143,584	115,313		
	B - EMPLOYEE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS	4.00	30,497	0		1.00
	TOTALS		30,497	0		
	C - RHC UTILITIES RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	0	11,312		1.00
	TOTALS		0	11,312		
500.00	Grand Total: Increases		174,081	126,625		500.00

RECLASSIFICATIONS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/18/2012 10:36 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	143,584	115,313	0		1.00
	TOTALS		143,584	115,313			
	B - EMPLOYEE BENEFIT RECLASS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	30,497	0	0		1.00
	TOTALS		30,497	0			
	C - RHC UTILITIES RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,312	0		1.00
	TOTALS		0	11,312			
500.00	Grand Total: Decreases		174,081	126,625			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/18/2012 10:36 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	20,150	0	0	0	0	1.00
2.00	Land Improvements	349,421	8,600	0	8,600	4,850	2.00
3.00	Buildings and Fixtures	5,333,809	104,512	0	104,512	172,012	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	499,757	0	0	0	0	5.00
6.00	Movable Equipment	4,490,132	221,924	0	221,924	234,751	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,693,269	335,036	0	335,036	411,613	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	10,693,269	335,036	0	335,036	411,613	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	208,806	0	0	35,726	20,845	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	331,314	0	35,102	0	0	2.00
3.00	Total (sum of lines 1-2)	540,120	0	35,102	35,726	20,845	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	6,139,387	0	6,139,387	0.578277	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,477,305	0	4,477,305	0.421723	0	2.00
3.00	Total (sum of lines 1-2)	10,616,692	0	10,616,692	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/18/2012 10:36 am

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	20,150	0	1.00
2.00	Land Improvements	353,171	0	2.00
3.00	Buildings and Fixtures	5,266,309	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	499,757	0	5.00
6.00	Movable Equipment	4,477,305	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,616,692	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	10,616,692	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	265,377	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	366,416	2.00
3.00	Total (sum of lines 1-2)	0	631,793	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	208,806	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	331,314	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	540,120	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	35,726	20,845	0	265,377	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	30,485	0	0	0	361,799	2.00
3.00	Total (sum of lines 1-2)	30,485	35,726	20,845	0	627,176	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/18/2012 10:36 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - buildings and fixtures (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)	B	-4,497	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)	B	-21,740	PURCHASING, RECEIVING AND STORES	5.02	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-426,892			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	-75,710	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-5,242	MEDICAL RECORDS & LIBRARY	16.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	PHYSICIAN MALPRACTICE COSTS	A	-9,420	EMERGENCY	91.00	33.00
34.00	MISC. EXPENSE - ADMIN	A	-8,398	OTHER ADMINISTRATIVE AND GENERAL	5.04	34.00
35.00	DONATION EXPENSE	A	-10,967	OTHER ADMINISTRATIVE AND GENERAL	5.04	35.00
36.00	MISC. REVENUE - ADMIN	B	-1,786	OTHER ADMINISTRATIVE AND GENERAL	5.04	36.00
37.00	PHYSICIAN RECRUITMENT	A	-8,375	OTHER ADMINISTRATIVE AND GENERAL	5.04	37.00
38.00	TELEPHONE OFFSET	A	-120	NEW CAP REL COSTS-MVBLE EQUIP	2.00	38.00
39.00	TELEPHONE OFFSET	A	-2,087	OTHER ADMINISTRATIVE AND GENERAL	5.04	39.00
40.00	TELEPHONE OFFSET	A	-567	EMPLOYEE BENEFITS	4.00	40.00
41.00	LOBBYING EXPENSE	A	-5,533	OTHER ADMINISTRATIVE AND GENERAL	5.04	41.00
42.00	PART B PHYSICIAN BILLING COSTS	A	-26,022	ADMINISTRATIVE & GENERAL	5.01	42.00
43.00	ADVERTISING - ADMIN	A	-22,854	OTHER ADMINISTRATIVE AND GENERAL	5.04	43.00
44.00	ADVERTISING - RHC	A	-63	RURAL HEALTH CLINIC	88.00	44.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/18/2012 10:36 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	ADVERTISING - CLINIC	A	-62	CLINIC	90.00	45.00
45.01	PHYSICIAN COST OFFSET	A	-279,847	CLINIC	90.00	45.01
45.02	ANESTHESIA BENEFITS	A	-9,605	ANESTHESIOLOGY	53.00	45.02
45.03	COST OF RHC PHYSICIANS SPENT IN HOSP	A	-47,840	RURAL HEALTH CLINIC	88.00	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-967,627			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/18/2012 10:36 am

		Wkst. A-7 Ref. 5.00		
1.00	Investment income - buildings and fixtures (chapter 2)	0		1.00
2.00	Investment income - movable equipment (chapter 2)	11		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - buildings and fixtures	0		26.00
27.00	Depreciation - movable equipment	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	PHYSICIAN MALPRACTICE COSTS	0		33.00
34.00	MISC. EXPENSE - ADMIN	0		34.00
35.00	DONATION EXPENSE	0		35.00
36.00	MISC. REVENUE - ADMIN	0		36.00
37.00	PHYSICIAN RECRUITMENT	0		37.00
38.00	TELEPHONE OFFSET	11		38.00
39.00	TELEPHONE OFFSET	0		39.00
40.00	TELEPHONE OFFSET	0		40.00
41.00	LOBBYING EXPENSE	0		41.00
42.00	PART B PHYSICIAN BILLING COSTS	0		42.00
43.00	ADVERTISING - ADMIN	0		43.00
44.00	ADVERTISING - RHC	0		44.00
45.00	ADVERTISING - CLINIC	0		45.00
45.01	PHYSICIAN COST OFFSET	0		45.01
45.02	ANESTHESIA BENEFITS	0		45.02
45.03	COST OF RHC PHYSICIANS SPENT IN HOSP	0		45.03
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: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/18/2012 10:36 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		66.01	CARDIAC REHAB	185	185	1.00
2.00		91.00	EMERGENCY	897,103	176,707	2.00
3.00		53.00	ANESTHESIOLOGIST	250,000	250,000	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00			TOTAL (lines 1.00 through 199.00)	1,147,288	426,892	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/18/2012 10:36 am

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		0	0	0	0	0	1.00
2.00		720,396	0	7,035	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		720,396		7,035	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/18/2012 10:36 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: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/18/2012 10:36 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	185		1.00
2.00		0	176,707		2.00
3.00		0	250,000		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	426,892		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/18/2012 10:36 am

		Physical Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	13.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.26	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)	36.63	36.63	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)		952	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)		952	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)		952	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)		73.23	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		57,119	22.00
23.00	Total salary equivalency (see instructions)		57,119	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)		13,370	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)		13,370	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		13,370	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)		13,370	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: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/18/2012 10:36 am
		Physical Therapy	Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.26	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)	57,119	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	13,370	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)	70,489	63.00	
64.00	Total cost of outside supplier services (from your records)	750	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00	
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,370	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,370	100.02	
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01	
101.02	Line 34 = sum of lines 27 and 31	0	101.02	
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01	
102.02	Line 35 = sum of lines 31 and 32	0	102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/18/2012 10:36 am

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	45.00	84.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	65.93	52.43	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)	26.22	26.22	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	2,967	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	4,404	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)	7,371	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)	7,371	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)	57.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	44,569	22.00
23.00	Total salary equivalency (see instructions)	44,569	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)	9,570	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)	9,570	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	9,570	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/18/2012 10:36 am
		Respiratory 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)	52.43	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)	44,569	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00	
60.00	Overtime allowance (from column 5, line 56)	0	60.00	
61.00	Equipment cost (see instructions)	0	61.00	
62.00	Supplies (see instructions)	0	62.00	
63.00	Total allowance (sum of lines 57-62)	44,569	63.00	
64.00	Total cost of outside supplier services (from your records)	3,720	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	9,570	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27	9,570	100.02	
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01	
101.02	Line 34 = sum of lines 27 and 31	0	101.02	
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01	
102.02	Line 35 = sum of lines 31 and 32	0	102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/18/2012 10:36 am

		Speech Pathology	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	106.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	66.75	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)	33.38	33.38	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)		7,076	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		7,076	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)		7,076	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)		66.75	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		52,065	22.00
23.00	Total salary equivalency (see instructions)		52,065	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)		12,184	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)		12,184	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		12,184	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)		12,184	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: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/18/2012 10:36 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)	66.75	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)	52,065	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	12,184	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)	64,249	63.00
64.00	Total cost of outside supplier services (from your records)	8,016	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	12,184	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	12,184	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/18/2012 10:36 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	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	5.01	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	265,377	265,377				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	361,799		361,799			2.00
4.00	EMPLOYEE BENEFITS	1,656,579	0	0	1,656,579		4.00
5.01	ADMINISTRATIVE & GENERAL	550,809	8,741	2,671	104,264	666,485	5.01
5.02	PURCHASING, RECEIVING AND STORES	45,321	2,410	0	22,028	0	5.02
5.03	COMMUNICATIONS	53,807	0	0	0	0	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	1,101,297	20,699	19,540	68,790	0	5.04
6.00	MAINTENANCE & REPAIRS	239,032	0	0	53,165	0	6.00
7.00	OPERATION OF PLANT	106,015	59,661	8,167	0	0	7.00
8.00	LAUNDRY & LINEN SERVICE	51,067	0	0	0	0	8.00
9.00	HOUSEKEEPING	183,850	3,446	0	59,545	0	9.00
10.00	DIETARY	93,673	4,198	619	19,193	0	10.00
11.00	CAFETERIA	183,187	8,741	1,857	53,047	0	11.00
13.00	NURSING ADMINISTRATION	152,861	1,029	0	48,166	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	178,866	1,791	0	57,862	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	247,533	5,959	2,362	72,250	0	16.00
17.00	SOCIAL SERVICE	54,658	213	0	19,961	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	662	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	897,241	27,341	22,470	305,359	50,427	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	312,790	23,857	23,173	64,062	58,444	50.00
53.00	ANESTHESIOLOGY	45,228	516	3,846	5,649	9,180	53.00
54.00	RADIOLOGY-DIAGNOSTIC	913,931	9,921	150,927	76,967	152,065	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	806,757	4,365	10,210	156,004	140,973	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	54,313	1,063	0	0	7,412	62.00
65.00	RESPIRATORY THERAPY	169,800	3,404	729	53,619	23,737	65.00
66.00	PHYSICAL THERAPY	120,511	4,482	541	40,122	9,814	66.00
66.01	CARDIAC REHAB	49,748	1,822	11,786	18,057	1,265	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,663	2,144	0	0	22,925	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	150,420	0	122	0	46,682	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	7,754	0	0	136	514	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	847,489	29,394	49,352	140,250	36,723	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	85,944	9,378	16,558	21,411	3,070	90.00
91.00	EMERGENCY	1,119,839	9,040	5,380	133,856	90,888	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	213,927	0	304	62,816	12,366	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,381,748	243,615	330,614	1,656,579	666,485	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19,814	21,762	31,185	0	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	11,401,562	265,377	361,799	1,656,579	666,485	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	PURCHASING, RECEIVING AND STORES	COMMUNICATIONS	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.02	5.03	5A.03	5.04	6.00	
	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	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES	69,759					5.02
5.03	COMMUNICATIONS	0	53,807				5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	3,508	6,457	1,220,291	1,220,291		5.04
6.00	MAINTENANCE & REPAIRS	3,110	0	295,307	35,394	330,701	6.00
7.00	OPERATION OF PLANT	76	3,587	177,506	21,275	84,487	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	51,067	6,121	0	8.00
9.00	HOUSEKEEPING	2,694	359	249,894	29,951	4,880	9.00
10.00	DIETARY	1,063	1,435	120,181	14,404	5,944	10.00
11.00	CAFETERIA	3,189	0	250,021	29,967	12,378	11.00
13.00	NURSING ADMINISTRATION	2,233	2,870	207,159	24,829	1,457	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	238,519	28,588	2,537	15.00
16.00	MEDICAL RECORDS & LIBRARY	590	5,022	333,716	39,998	8,438	16.00
17.00	SOCIAL SERVICE	76	717	75,625	9,064	301	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	662	79	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,890	10,043	1,320,771	158,302	38,718	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,133	2,870	492,329	59,009	33,784	50.00
53.00	ANESTHESIOLOGY	1,394	359	66,172	7,931	731	53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,721	2,152	1,312,684	157,333	14,049	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	8,610	1,794	1,128,713	135,283	6,181	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,420	0	64,208	7,696	1,505	62.00
65.00	RESPIRATORY THERAPY	693	1,794	253,776	30,417	4,821	65.00
66.00	PHYSICAL THERAPY	237	1,076	176,783	21,189	6,347	66.00
66.01	CARDIAC REHAB	46	717	83,441	10,001	2,580	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,200	0	91,932	11,019	3,037	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	709	717	198,650	23,809	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	47	0	8,451	1,013	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	2,167	6,816	1,112,191	133,303	41,626	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	1,044	2,152	139,557	16,727	13,280	90.00
91.00	EMERGENCY	4,182	2,870	1,366,055	163,734	12,802	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	2,607	0	292,020	35,000	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	68,639	53,807	11,327,681	1,211,436	299,883	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	72,761	8,721	30,818	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	1,120	0	1,120	134	0	194.00
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)	69,759	53,807	11,401,562	1,220,291	330,701	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/18/2012 10:36 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	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES						5.02
5.03	COMMUNICATIONS						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT	283,268					7.00
8.00	LAUNDRY & LINEN SERVICE	0	57,188				8.00
9.00	HOUSEKEEPING	8,097	0	292,822			9.00
10.00	DIETARY	9,862	99	9,893	160,383		10.00
11.00	CAFETERIA	20,536	0	29,646	0	342,548	11.00
13.00	NURSING ADMINISTRATION	2,417	0	629	0	7,288	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	4,209	0	463	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	14,000	0	3,540	0	25,509	16.00
17.00	SOCIAL SERVICE	499	0	0	0	3,644	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	64,237	35,931	63,365	160,383	83,816	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	56,053	6,337	29,514	0	14,577	50.00
53.00	ANESTHESIOLOGY	1,213	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	23,309	3,900	13,797	0	25,509	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	10,255	0	12,705	0	40,085	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,497	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	7,999	320	3,176	0	18,221	65.00
66.00	PHYSICAL THERAPY	10,531	1,757	7,014	0	7,288	66.00
66.01	CARDIAC REHAB	4,280	0	4,334	0	3,644	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,288	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	31,896	0	40,085	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	22,034	13	14,922	0	7,288	90.00
91.00	EMERGENCY	21,240	8,355	30,540	0	32,797	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	476	66	0	25,509	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	283,268	57,188	255,500	160,383	342,548	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	37,322	0	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	283,268	57,188	292,822	160,383	342,548	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES						5.02
5.03	COMMUNICATIONS						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	243,779					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	PHARMACY	0	0	274,316			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	425,201		16.00
17.00	SOCIAL SERVICE	0	0	0	0	89,133	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	146,563	0	0	218,928	89,133	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	28,684	0	0	39,546	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	15,186	0	65.00
66.00	PHYSICAL THERAPY	10,834	0	0	0	0	66.00
66.01	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	274,316	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	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	57,698	0	0	151,541	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	243,779	0	274,316	425,201	89,133	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	243,779	0	274,316	425,201	89,133	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		19.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES						5.02
5.03	COMMUNICATIONS						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
17.00	SOCIAL SERVICE						17.00
19.00	NONPHYSICIAN ANESTHETISTS	741					19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	213	2,380,360	0	2,380,360		30.00
40.00	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0	0		42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	186	760,019	0	760,019		50.00
53.00	ANESTHESIOLOGY	4	76,051	0	76,051		53.00
54.00	RADIOLOGY-DIAGNOSTIC	77	1,550,658	0	1,550,658		54.00
57.00	CT SCAN	0	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	LABORATORY	34	1,333,256	0	1,333,256		60.00
60.01	BLOOD LABORATORY	0	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	8	75,914	0	75,914		62.00
65.00	RESPIRATORY THERAPY	27	333,943	0	333,943		65.00
66.00	PHYSICAL THERAPY	35	241,778	0	241,778		66.00
66.01	CARDIAC REHAB	14	108,294	0	108,294		66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	105,988	0	105,988		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	504,063	0	504,063		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	9,464	0	9,464		76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,359,101	0	1,359,101		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	CLINIC	73	213,894	0	213,894		90.00
91.00	EMERGENCY	70	1,844,832	0	1,844,832		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	FAMILY PRACTICE	0	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	353,071	0	353,071		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
118.00	SUBTOTALS (SUM OF LINES 1-117)	741	11,250,686	0	11,250,686		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	149,622	0	149,622		192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0		192.01
192.02	LSC	0	0	0	0		192.02
192.03	PUBLIC RELATIONS	0	0	0	0		192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	1,254	0	1,254		194.00
200.00	Cross Foot Adjustments	0	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	741	11,401,562	0	11,401,562		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/18/2012 10:36 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	ADMINISTRATIVE & GENERAL	0	8,741	2,671	11,412	0	5.01
5.02	PURCHASING, RECEIVING AND STORES	0	2,410	0	2,410	0	5.02
5.03	COMMUNICATIONS	0	0	0	0	0	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	0	20,699	19,540	40,239	0	5.04
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	59,661	8,167	67,828	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	3,446	0	3,446	0	9.00
10.00	DIETARY	0	4,198	619	4,817	0	10.00
11.00	CAFETERIA	0	8,741	1,857	10,598	0	11.00
13.00	NURSING ADMINISTRATION	0	1,029	0	1,029	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	1,791	0	1,791	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	5,959	2,362	8,321	0	16.00
17.00	SOCIAL SERVICE	0	213	0	213	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	27,341	22,470	49,811	0	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	23,857	23,173	47,030	0	50.00
53.00	ANESTHESIOLOGY	0	516	3,846	4,362	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	9,921	150,927	160,848	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	4,365	10,210	14,575	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,063	0	1,063	0	62.00
65.00	RESPIRATORY THERAPY	0	3,404	729	4,133	0	65.00
66.00	PHYSICAL THERAPY	0	4,482	541	5,023	0	66.00
66.01	CARDIAC REHAB	0	1,822	11,786	13,608	0	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,144	0	2,144	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	122	122	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	29,394	49,352	78,746	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	9,378	16,558	25,936	0	90.00
91.00	EMERGENCY	0	9,040	5,380	14,420	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	304	304	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	243,615	330,614	574,229	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	21,762	31,185	52,947	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	265,377	361,799	627,176	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	PURCHASING, RECEIVING AND STORES	COMMUNICATIONS	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.01	5.02	5.03	5.04	6.00	
	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	ADMINISTRATIVE & GENERAL	11,412					5.01
5.02	PURCHASING, RECEIVING AND STORES	0	2,410				5.02
5.03	COMMUNICATIONS	0	0	0			5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	0	121	0	40,360		5.04
6.00	MAINTENANCE & REPAIRS	0	107	0	1,171	1,278	6.00
7.00	OPERATION OF PLANT	0	3	0	704	324	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	202	0	8.00
9.00	HOUSEKEEPING	0	93	0	991	19	9.00
10.00	DIETARY	0	37	0	476	23	10.00
11.00	CAFETERIA	0	110	0	991	48	11.00
13.00	NURSING ADMINISTRATION	0	77	0	821	6	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	945	10	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	20	0	1,323	33	16.00
17.00	SOCIAL SERVICE	0	3	0	300	1	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	3	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	864	273	0	5,236	150	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,001	246	0	1,952	131	50.00
53.00	ANESTHESIOLOGY	157	48	0	262	3	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,598	232	0	5,203	54	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	2,415	297	0	4,474	24	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	127	49	0	255	6	62.00
65.00	RESPIRATORY THERAPY	407	24	0	1,006	19	65.00
66.00	PHYSICAL THERAPY	168	8	0	701	25	66.00
66.01	CARDIAC REHAB	22	2	0	331	10	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	393	249	0	364	12	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	800	25	0	787	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	9	2	0	33	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	629	75	0	4,409	161	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	53	36	0	553	51	90.00
91.00	EMERGENCY	1,557	144	0	5,417	49	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	212	90	0	1,158	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,412	2,371	0	40,068	1,159	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	288	119	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	39	0	4	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	11,412	2,410	0	40,360	1,278	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/18/2012 10:36 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	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES						5.02
5.03	COMMUNICATIONS						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT	68,859					7.00
8.00	LAUNDRY & LINEN SERVICE	0	202				8.00
9.00	HOUSEKEEPING	1,968	0	6,517			9.00
10.00	DIETARY	2,397	0	220	7,970		10.00
11.00	CAFETERIA	4,992	0	660	0	17,399	11.00
13.00	NURSING ADMINISTRATION	587	0	14	0	370	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	1,023	0	10	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,403	0	79	0	1,296	16.00
17.00	SOCIAL SERVICE	121	0	0	0	185	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	15,618	127	1,410	7,970	4,258	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	13,626	22	657	0	740	50.00
53.00	ANESTHESIOLOGY	295	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	5,666	14	307	0	1,296	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	2,493	0	283	0	2,036	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	607	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	1,944	1	71	0	925	65.00
66.00	PHYSICAL THERAPY	2,560	6	156	0	370	66.00
66.01	CARDIAC REHAB	1,040	0	96	0	185	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	370	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	710	0	2,036	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	5,356	0	332	0	370	90.00
91.00	EMERGENCY	5,163	30	680	0	1,666	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	2	1	0	1,296	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	68,859	202	5,686	7,970	17,399	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	831	0	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	68,859	202	6,517	7,970	17,399	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES						5.02
5.03	COMMUNICATIONS						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	2,904					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	PHARMACY	0	0	3,779			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	14,475		16.00
17.00	SOCIAL SERVICE	0	0	0	0	823	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,746	0	0	7,453	823	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	342	0	0	1,346	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	517	0	65.00
66.00	PHYSICAL THERAPY	129	0	0	0	0	66.00
66.01	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	3,779	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	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	687	0	0	5,159	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,904	0	3,779	14,475	823	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,904	0	3,779	14,475	823	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		19.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES						5.02
5.03	COMMUNICATIONS						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
17.00	SOCIAL SERVICE						17.00
19.00	NONPHYSICIAN ANESTHETISTS	3					19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		95,739	0	95,739		30.00
40.00	SUBPROVIDER - IPF		0	0	0		40.00
41.00	SUBPROVIDER - IRF		0	0	0		41.00
42.00	SUBPROVIDER		0	0	0		42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		67,093	0	67,093		50.00
53.00	ANESTHESIOLOGY		5,127	0	5,127		53.00
54.00	RADIOLOGY-DIAGNOSTIC		176,218	0	176,218		54.00
57.00	CT SCAN		0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0		58.00
59.00	CARDIAC CATHETERIZATION		0	0	0		59.00
60.00	LABORATORY		26,597	0	26,597		60.00
60.01	BLOOD LABORATORY		0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		2,107	0	2,107		62.00
65.00	RESPIRATORY THERAPY		9,047	0	9,047		65.00
66.00	PHYSICAL THERAPY		9,146	0	9,146		66.00
66.01	CARDIAC REHAB		15,294	0	15,294		66.01
69.00	ELECTROCARDIOLOGY		0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		3,162	0	3,162		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS		5,883	0	5,883		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS		44	0	44		76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		86,766	0	86,766		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0		89.00
90.00	CLINIC		32,687	0	32,687		90.00
91.00	EMERGENCY		34,972	0	34,972		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	FAMILY PRACTICE		0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES		3,063	0	3,063		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
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	572,945	0	572,945		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES		54,185	0	54,185		192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)		0	0	0		192.01
192.02	LSC		0	0	0		192.02
192.03	PUBLIC RELATIONS		0	0	0		192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS		43	0	43		194.00
200.00	Cross Foot Adjustments	3	3	0	3		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	3	627,176	0	627,176		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (GROSS CHARGES)	PURCHASING, RECEIVING AND STORES (COSTED REQUIS.)	
		1.00	2.00	4.00	5.01	5.02	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	69,923					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		432,582				2.00
4.00	EMPLOYEE BENEFITS	0	0	4,483,957			4.00
5.01	ADMINISTRATIVE & GENERAL	2,303	3,194	282,216	24,091,880		5.01
5.02	PURCHASING, RECEIVING AND STORES	635	0	59,625	0	578,090	5.02
5.03	COMMUNICATIONS	0	0	0	0	0	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	5,454	23,363	186,199	0	29,069	5.04
6.00	MAINTENANCE & REPAIRS	0	0	143,905	0	25,776	6.00
7.00	OPERATION OF PLANT	15,720	9,765	0	0	631	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	HOUSEKEEPING	908	0	161,173	0	22,324	9.00
10.00	DIETARY	1,106	740	51,951	0	8,808	10.00
11.00	CAFETERIA	2,303	2,220	143,584	0	26,423	11.00
13.00	NURSING ADMINISTRATION	271	0	130,373	0	18,506	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	472	0	156,618	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,570	2,824	195,564	0	4,890	16.00
17.00	SOCIAL SERVICE	56	0	54,029	0	629	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,204	26,866	826,541	1,822,840	65,386	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,286	27,707	173,400	2,112,635	59,110	50.00
53.00	ANESTHESIOLOGY	136	4,599	15,290	331,828	11,552	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,614	180,451	208,330	5,496,647	55,695	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,150	12,208	422,265	5,095,903	71,342	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	280	0	0	267,917	11,770	62.00
65.00	RESPIRATORY THERAPY	897	872	145,133	858,034	5,742	65.00
66.00	PHYSICAL THERAPY	1,181	647	108,601	354,761	1,963	66.00
66.01	CARDIAC REHAB	480	14,092	48,875	45,739	384	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	565	0	0	828,690	59,663	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	146	0	1,687,474	5,879	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	367	18,596	390	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	7,745	59,007	379,622	1,327,458	17,959	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	2,471	19,798	57,953	110,958	8,654	90.00
91.00	EMERGENCY	2,382	6,433	362,316	3,285,410	34,659	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	364	170,027	446,990	21,604	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	64,189	395,296	4,483,957	24,091,880	568,808	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	5,734	37,286	0	0	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	9,282	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	265,377	361,799	1,656,579	666,485	69,759	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.795275	0.836371	0.369446	0.027664	0.120672	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (GROSS CHARGES)	PURCHASING, RECEIVING AND STORES (COSTED REQUIS.)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
204.00	Cost to be allocated (per Wkst. B, Part II)			0	11,412	2,410	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000474	0.004169	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	COMMUNICATIONS (PHONES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (ASSIGNED SQ FEET)	
		5.03	5A.04	5.04	6.00	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	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES						5.02
5.03	COMMUNICATIONS	150					5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	18	-1,220,291	10,181,271			5.04
6.00	MAINTENANCE & REPAIRS	0	0	295,307	61,531		6.00
7.00	OPERATION OF PLANT	10	0	177,506	15,720	31,767	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	51,067	0	0	8.00
9.00	HOUSEKEEPING	1	0	249,894	908	908	9.00
10.00	DIETARY	4	0	120,181	1,106	1,106	10.00
11.00	CAFETERIA	0	0	250,021	2,303	2,303	11.00
13.00	NURSING ADMINISTRATION	8	0	207,159	271	271	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	238,519	472	472	15.00
16.00	MEDICAL RECORDS & LIBRARY	14	0	333,716	1,570	1,570	16.00
17.00	SOCIAL SERVICE	2	0	75,625	56	56	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	662	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	28	0	1,320,771	7,204	7,204	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8	0	492,329	6,286	6,286	50.00
53.00	ANESTHESIOLOGY	1	0	66,172	136	136	53.00
54.00	RADIOLOGY-DIAGNOSTIC	6	0	1,312,684	2,614	2,614	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	5	0	1,128,713	1,150	1,150	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	64,208	280	280	62.00
65.00	RESPIRATORY THERAPY	5	0	253,776	897	897	65.00
66.00	PHYSICAL THERAPY	3	0	176,783	1,181	1,181	66.00
66.01	CARDIAC REHAB	2	0	83,441	480	480	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	91,932	565	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2	0	198,650	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	8,451	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	19	0	1,112,191	7,745	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	6	0	139,557	2,471	2,471	90.00
91.00	EMERGENCY	8	0	1,366,055	2,382	2,382	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	292,020	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	150	-1,220,291	10,107,390	55,797	31,767	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	72,761	5,734	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	1,120	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	53,807		1,220,291	330,701	283,268	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	358.713333		0.119856	5.374543	8.917052	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0		40,360	1,278	68,859	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		0.003964	0.020770	2.167627	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		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	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES						5.02
5.03	COMMUNICATIONS						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE	90,367					8.00
9.00	HOUSEKEEPING	0	8,850				9.00
10.00	DIETARY	156	299	2,502			10.00
11.00	CAFETERIA	0	896	0	94		11.00
13.00	NURSING ADMINISTRATION	0	19	0	2	78,886	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	14	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	107	0	7	0	16.00
17.00	SOCIAL SERVICE	0	0	0	1	0	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	56,778	1,915	2,502	23	47,427	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	10,013	892	0	4	9,282	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,163	417	0	7	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	384	0	11	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	505	96	0	5	0	65.00
66.00	PHYSICAL THERAPY	2,776	212	0	2	3,506	66.00
66.01	CARDIAC REHAB	0	131	0	1	0	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	2	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	964	0	11	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	21	451	0	2	0	90.00
91.00	EMERGENCY	13,203	923	0	9	18,671	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	752	2	0	7	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	90,367	7,722	2,502	94	78,886	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,128	0	0	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	57,188	292,822	160,383	342,548	243,779	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.632842	33.087232	64.101918	3,644.127660	3.090270	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	202	6,517	7,970	17,399	2,904	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.002235	0.736384	3.185452	185.095745	0.036813	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED SQ FEET)	
		14.00	15.00	16.00	17.00	19.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINISTRATIVE & GENERAL						5.01
5.02	PURCHASING, RECEIVING AND STORES						5.02
5.03	COMMUNICATIONS						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY	446,553					14.00
15.00	PHARMACY	0	100				15.00
16.00	MEDICAL RECORDS & LIBRARY	4,890	0	1,344			16.00
17.00	SOCIAL SERVICE	629	0	0	100		17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	25,081	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	65,386	0	692	100		30.00
40.00	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0	0		42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	59,110	0	125	0	6,286	50.00
53.00	ANESTHESIOLOGY	11,552	0	0	0	136	53.00
54.00	RADIOLOGY-DIAGNOSTIC	55,695	0	0	0	2,614	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	71,342	0	0	0	1,150	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,770	0	0	0	280	62.00
65.00	RESPIRATORY THERAPY	5,742	0	48	0	897	65.00
66.00	PHYSICAL THERAPY	1,963	0	0	0	1,181	66.00
66.01	CARDIAC REHAB	384	0	0	0	480	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,663	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,879	100	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	390	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	17,959	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	8,654	0	0	0	2,471	90.00
91.00	EMERGENCY	34,659	0	479	0	2,382	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	21,604	0	0	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
118.00	SUBTOTALS (SUM OF LINES 1-117)	437,271	100	1,344	100	25,081	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	RURAL HEALTH CLINC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	LSC	0	0	0	0	0	192.02
192.03	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	OTHER NONREIMBURSABLE COST CENTERS	9,282	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	274,316	425,201	89,133	741	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	2,743.160000	316.369792	891.330000	0.029544	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	3,779	14,475	823	3	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	37.790000	10.770089	8.230000	0.000120	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/18/2012 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,380,360		2,380,360	0	0	30.00
40.00	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	760,019		760,019	0	0	50.00
53.00	ANESTHESIOLOGY	76,051		76,051	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,550,658		1,550,658	0	0	54.00
57.00	CT SCAN	0		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	1,333,256		1,333,256	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	75,914		75,914	0	0	62.00
65.00	RESPIRATORY THERAPY	333,943	0	333,943	0	0	65.00
66.00	PHYSICAL THERAPY	241,778	0	241,778	0	0	66.00
66.01	CARDIAC REHAB	108,294	0	108,294	0	0	66.01
69.00	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,988		105,988	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	504,063		504,063	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	9,464		9,464	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,359,101		1,359,101	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	213,894		213,894	0	0	90.00
91.00	EMERGENCY	1,844,832		1,844,832	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	10,646		10,646		0	92.00
93.00	FAMILY PRACTICE	0		0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	353,071		353,071	0	0	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
200.00	Subtotal (see instructions)	11,261,332	0	11,261,332	0	0	200.00
201.00	Less Observation Beds	10,646		10,646		0	201.00
202.00	Total (see instructions)	11,250,686	0	11,250,686	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/18/2012 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,810,938		1,810,938			30.00
40.00	SUBPROVIDER - IPF	0		0			40.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	75,300	2,037,335	2,112,635	0.359749	0.000000	50.00
53.00	ANESTHESIOLOGY	35,357	296,471	331,828	0.229188	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	675,570	4,821,077	5,496,647	0.282110	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	788,833	4,307,070	5,095,903	0.261633	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	210,778	57,139	267,917	0.283349	0.000000	62.00
65.00	RESPIRATORY THERAPY	564,705	293,329	858,034	0.389196	0.000000	65.00
66.00	PHYSICAL THERAPY	84,673	270,088	354,761	0.681524	0.000000	66.00
66.01	CARDIAC REHAB	0	45,739	45,739	2.367651	0.000000	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	800,488	28,202	828,690	0.127898	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,260,974	426,500	1,687,474	0.298709	0.000000	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	18,596	18,596	0.508927	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	117,814	1,209,644	1,327,458			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	33,729	77,229	110,958	1.927702	0.000000	90.00
91.00	EMERGENCY	117,935	3,167,475	3,285,410	0.561523	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,902	11,902	0.894472	0.000000	92.00
93.00	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	2,400	444,590	446,990	0.789886	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
200.00	Subtotal (see instructions)	6,579,494	17,512,386	24,091,880			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	6,579,494	17,512,386	24,091,880			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/18/2012 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
	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
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
66.01	CARDIAC REHAB	0.000000		66.01
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
	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	FAMILY PRACTICE	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
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/18/2012 10:36 am

Title XIX | Hospital

	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	2,380,360		2,380,360	0	0	30.00
40.00	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	760,019		760,019	0	0	50.00
53.00	ANESTHESIOLOGY	76,051		76,051	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,550,658		1,550,658	0	0	54.00
57.00	CT SCAN	0		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	1,333,256		1,333,256	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	75,914		75,914	0	0	62.00
65.00	RESPIRATORY THERAPY	333,943	0	333,943	0	0	65.00
66.00	PHYSICAL THERAPY	241,778	0	241,778	0	0	66.00
66.01	CARDIAC REHAB	108,294	0	108,294	0	0	66.01
69.00	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	105,988		105,988	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	504,063		504,063	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	9,464		9,464	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,359,101		1,359,101	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	213,894		213,894	0	0	90.00
91.00	EMERGENCY	1,844,832		1,844,832	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	10,643		10,643		0	92.00
93.00	FAMILY PRACTICE	0		0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	353,071		353,071	0	0	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
200.00	Subtotal (see instructions)	11,261,329	0	11,261,329	0	0	200.00
201.00	Less Observation Beds	10,643		10,643		0	201.00
202.00	Total (see instructions)	11,250,686	0	11,250,686	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/18/2012 10:36 am

Title XIX | Hospital

	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	1,810,938		1,810,938			30.00
40.00	SUBPROVIDER - IPF	0		0			40.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	75,300	2,037,335	2,112,635	0.359749	0.000000	50.00
53.00	ANESTHESIOLOGY	35,357	296,471	331,828	0.229188	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	675,570	4,821,077	5,496,647	0.282110	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	788,833	4,307,070	5,095,903	0.261633	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	210,778	57,139	267,917	0.283349	0.000000	62.00
65.00	RESPIRATORY THERAPY	564,705	293,329	858,034	0.389196	0.000000	65.00
66.00	PHYSICAL THERAPY	84,673	270,088	354,761	0.681524	0.000000	66.00
66.01	CARDIAC REHAB	0	45,739	45,739	2.367651	0.000000	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	800,488	28,202	828,690	0.127898	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,260,974	426,500	1,687,474	0.298709	0.000000	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	18,596	18,596	0.508927	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	117,814	1,209,644	1,327,458	1.023837	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	CLINIC	33,729	77,229	110,958	1.927702	0.000000	90.00
91.00	EMERGENCY	117,935	3,167,475	3,285,410	0.561523	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,902	11,902	0.894219	0.000000	92.00
93.00	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	2,400	444,590	446,990	0.789886	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
200.00	Subtotal (see instructions)	6,579,494	17,512,386	24,091,880			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	6,579,494	17,512,386	24,091,880			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/18/2012 10:36 am

Title XIX | Hospital

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
	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
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
66.01	CARDIAC REHAB	0.000000		66.01
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
	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		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	FAMILY PRACTICE	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
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: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part II Date/Time Prepared: 1/18/2012 10:36 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	67,093	2,112,635	0.031758	44,554	1,415	50.00
53.00	ANESTHESIOLOGY	5,127	331,828	0.015451	2,756	43	53.00
54.00	RADIOLOGY-DIAGNOSTIC	176,218	5,496,647	0.032059	364,619	11,689	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	26,597	5,095,903	0.005219	620,358	3,238	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,107	267,917	0.007864	63,649	501	62.00
65.00	RESPIRATORY THERAPY	9,047	858,034	0.010544	405,469	4,275	65.00
66.00	PHYSICAL THERAPY	9,146	354,761	0.025781	43,054	1,110	66.00
66.01	CARDIAC REHAB	15,294	45,739	0.334375	0	0	66.01
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,162	828,690	0.003816	550,431	2,100	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,883	1,687,474	0.003486	784,950	2,736	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	44	18,596	0.002366	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	86,766	1,327,458	0.065363	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	32,687	110,958	0.294589	0	0	90.00
91.00	EMERGENCY	34,972	3,285,410	0.010645	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,902	0.000000	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0.000000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	474,143	21,833,952		2,879,840	27,107	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/18/2012 10:36 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	186	0	0	0	186	50.00
53.00	ANESTHESIOLOGY	4	0	0	0	4	53.00
54.00	RADIOLOGY-DIAGNOSTIC	77	0	0	0	77	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	34	0	0	0	34	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	8	0	0	0	8	62.00
65.00	RESPIRATORY THERAPY	27	0	0	0	27	65.00
66.00	PHYSICAL THERAPY	35	0	0	0	35	66.00
66.01	CARDIAC REHAB	14	0	0	0	14	66.01
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
	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	73	0	0	0	73	90.00
91.00	EMERGENCY	70	0	0	0	70	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	528	0	0	0	528	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/18/2012 10:36 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	2,112,635	8.8E-5	0.000000	44,554	50.00
53.00	ANESTHESIOLOGY	0	331,828	1.2E-5	0.000000	2,756	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	5,496,647	1.4E-5	0.000000	364,619	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	5,095,903	7E-6	0.000000	620,358	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	267,917	3E-5	0.000000	63,649	62.00
65.00	RESPIRATORY THERAPY	0	858,034	3.1E-5	0.000000	405,469	65.00
66.00	PHYSICAL THERAPY	0	354,761	9.9E-5	0.000000	43,054	66.00
66.01	CARDIAC REHAB	0	45,739	0.000306	0.000000	0	66.01
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	828,690	0.000000	0.000000	550,431	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,687,474	0.000000	0.000000	784,950	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	18,596	0.000000	0.000000	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,327,458	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	110,958	0.000658	0.000000	0	90.00
91.00	EMERGENCY	0	3,285,410	2.1E-5	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,902	0.000000	0.000000	0	92.00
93.00	FAMILY PRACTICE	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	21,833,952			2,879,840	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/18/2012 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	4	0	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	5	0	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	4	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	2	0	0		62.00
65.00	RESPIRATORY THERAPY	13	0	0		65.00
66.00	PHYSICAL THERAPY	4	0	0		66.00
66.01	CARDIAC REHAB	0	0	0		66.01
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
	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	FAMILY PRACTICE	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	32	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/18/2012 10:36 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	0.359749	0	745,236	0		50.00
53.00	ANESTHESIOLOGY	0.229188	0	31,647	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.282110	0	1,509,560	0		54.00
57.00	CT SCAN	0.000000	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	LABORATORY	0.261633	0	1,655,224	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.283349	0	43,325	0		62.00
65.00	RESPIRATORY THERAPY	0.389196	0	164,311	0		65.00
66.00	PHYSICAL THERAPY	0.681524	0	116,530	0		66.00
66.01	CARDIAC REHAB	2.367651	0	32,542	0		66.01
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127898	0	28,202	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298709	0	247,823	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.508927	0	0	0		76.00
	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	1.927702	0	41,564	0		90.00
91.00	EMERGENCY	0.561523	0	1,084,565	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.894472	0	6,623	0		92.00
93.00	FAMILY PRACTICE	0.000000	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.789886		0			95.00
200.00	Subtotal (see instructions)		0	5,707,152	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	5,707,152	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/18/2012 10:36 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	268,098	0		50.00
53.00	ANESTHESIOLOGY	0	7,253	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	425,862	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	433,061	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	12,276	0		62.00
65.00	RESPIRATORY THERAPY	0	63,949	0		65.00
66.00	PHYSICAL THERAPY	0	79,418	0		66.00
66.01	CARDIAC REHAB	0	77,048	0		66.01
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,607	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	74,027	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
	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	80,123	0		90.00
91.00	EMERGENCY	0	609,008	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,924	0		92.00
93.00	FAMILY PRACTICE	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	2,139,654	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	2,139,654	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141344 | Component CCN: 14Z344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/18/2012 10:36 am

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.359749	0	0	0		50.00
53.00	ANESTHESIOLOGY	0.229188	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.282110	0	0	0		54.00
57.00	CT SCAN	0.000000	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	LABORATORY	0.261633	0	0	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.283349	0	0	0		62.00
65.00	RESPIRATORY THERAPY	0.389196	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.681524	0	0	0		66.00
66.01	CARDIAC REHAB	2.367651	0	0	0		66.01
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127898	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298709	0	0	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.508927	0	0	0		76.00
	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	1.927702	0	0	0		90.00
91.00	EMERGENCY	0.561523	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.894472	0	0	0		92.00
93.00	FAMILY PRACTICE	0.000000	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.789886		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: 141344 | Component CCN: 14Z344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/18/2012 10:36 am

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Costs: PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
66.01	CARDIAC REHAB	0	0	0		66.01
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
	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	FAMILY PRACTICE	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 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/18/2012 10:36 am

Title XIX | Hospital

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.359749	0	642,779	0		50.00
53.00	ANESTHESIOLOGY	0.229188	0	151,996	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.282110	0	1,448,947	0		54.00
57.00	CT SCAN	0.000000	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	LABORATORY	0.261633	0	960,615	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.283349	0	13,580	0		62.00
65.00	RESPIRATORY THERAPY	0.389196	0	49,547	0		65.00
66.00	PHYSICAL THERAPY	0.681524	0	50,419	0		66.00
66.01	CARDIAC REHAB	2.367651	0	1,696	0		66.01
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127898	0	56,847	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298709	0	112,191	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.508927	0	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1.023837					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	1.927702	0	190,195	0		90.00
91.00	EMERGENCY	0.561523	0	1,501,406	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.894219	0	0	0		92.00
93.00	FAMILY PRACTICE	0.000000	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.789886	0	86,848			95.00
200.00	Subtotal (see instructions)		0	5,267,066	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	5,267,066	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/18/2012 10:36 am

Title XIX | Hospital

	Cost Center Description	Costs PPS Services (see instructions)	Costs Cost Services Subject To Ded. & Coins. (see instructions)	Costs Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	231,239	0		50.00
53.00	ANESTHESIOLOGY	0	34,836	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	408,762	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	251,329	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,848	0		62.00
65.00	RESPIRATORY THERAPY	0	19,283	0		65.00
66.00	PHYSICAL THERAPY	0	34,362	0		66.00
66.01	CARDIAC REHAB	0	4,016	0		66.01
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,271	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	33,512	0		73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
	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	366,639	0		90.00
91.00	EMERGENCY	0	843,074	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	FAMILY PRACTICE	0	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		68,600			95.00
200.00	Subtotal (see instructions)	0	2,306,771	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	2,306,771	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/18/2012 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,145	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,499	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,499	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)	627	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)	19	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,975	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)	627	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	168.58	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	173.64	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,380,360	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)	3,299	25.00
26.00	Total swing-bed cost (see instructions)	480,082	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,900,278	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	0	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)	1,900,278	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)	760.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,501,830	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,501,830	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/18/2012 10:36 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)	791,884	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,293,714	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	476,783	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	476,783	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)	14	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	760.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	10,646	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/18/2012 10:36 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: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/18/2012 10:36 am

Title XIX | Hospital

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,145	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,499	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,499	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)	627	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)	19	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	232	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	202.30	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	202.30	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,380,360	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)	3,844	25.00
26.00	Total swing-bed cost (see instructions)	480,514	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,899,846	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,716,762	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,716,762	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.106645	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)	686.98	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)	1,899,846	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)	760.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	176,376	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)	176,376	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/18/2012 10:36 am

Title XIX | Hospital

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	176,376	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)	176,376	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	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)	14	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	760.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	10,643	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/18/2012 10:36 am

Title XIX | Hospital

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	1,899,846	0.000000	10,643	0	90.00
91.00	Nursing School cost	0	1,899,846	0.000000	10,643	0	91.00
92.00	Allied health cost	0	1,899,846	0.000000	10,643	0	92.00
93.00	All other Medical Education	0	1,899,846	0.000000	10,643	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/18/2012 10:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		1,276,779		30.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.359749	44,554	16,028	50.00
53.00	ANESTHESIOLOGY	0.229188	2,756	632	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.282110	364,619	102,863	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.261633	620,358	162,306	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.283349	63,649	18,035	62.00
65.00	RESPIRATORY THERAPY	0.389196	405,469	157,807	65.00
66.00	PHYSICAL THERAPY	0.681524	43,054	29,342	66.00
66.01	CARDIAC REHAB	2.367651	0	0	66.01
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127898	550,431	70,399	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298709	784,950	234,472	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.508927	0	0	76.00
	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	1.927702	0	0	90.00
91.00	EMERGENCY	0.561523	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.894472	0	0	92.00
93.00	FAMILY PRACTICE	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)		2,879,840	791,884	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)		2,879,840		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141344 | Component CCN: 14Z344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/18/2012 10:36 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
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.359749	1,155	416	50.00
53.00	ANESTHESIOLOGY	0.229188	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.282110	33,074	9,331	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.261633	65,062	17,022	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.283349	11,394	3,228	62.00
65.00	RESPIRATORY THERAPY	0.389196	124,311	48,381	65.00
66.00	PHYSICAL THERAPY	0.681524	40,208	27,403	66.00
66.01	CARDIAC REHAB	2.367651	0	0	66.01
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.127898	182,013	23,279	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298709	258,471	77,208	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.508927	0	0	76.00
	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	1.927702	0	0	90.00
91.00	EMERGENCY	0.561523	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.894472	0	0	92.00
93.00	FAMILY PRACTICE	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)		715,688	206,268	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)		715,688		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/18/2012 10:36 am

Title XIX | Hospital

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		153,473		30.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000	27,487	0	50.00
53.00	ANESTHESIOLOGY	0.000000	9,842	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	59,351	0	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.000000	89,043	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	4,409	0	62.00
65.00	RESPIRATORY THERAPY	0.000000	34,925	0	65.00
66.00	PHYSICAL THERAPY	0.000000	1,411	0	66.00
66.01	CARDIAC REHAB	0.000000	0	0	66.01
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	31,731	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	95,384	0	73.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000	10,655	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	0.000000	7,021	0	90.00
91.00	EMERGENCY	0.000000	6,904	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
93.00	FAMILY PRACTICE	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)		378,163	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		378,163		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/18/2012 10:36 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,139,654	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)	2,139,654	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)	2,161,051	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)	42,525	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	799,028	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)	1,319,498	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)	1,319,498	30.00
31.00	Primary payer payments	110	31.00
32.00	Subtotal (line 30 minus line 31)	1,319,388	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)	247,165	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	247,165	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	221,848	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,566,553	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)	1,566,553	40.00
41.00	Interim payments	1,666,242	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)	-99,689	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I Date/Time Prepared: 1/18/2012 10:36 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		1,865,212		1,666,242	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		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	01/21/2011	52,000		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		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)		52,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,917,212		1,666,242	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		31,197		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		99,689	6.02
7.00	Total Medicare program liability (see instructions)		1,948,409		1,566,553	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: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/18/2012 10:36 am

Component CCN: 14Z344 | 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		632,991		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	01/21/2011	21,200		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		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)		21,200		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)		654,191		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		24,531		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		678,722		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: 141344 Component CCN: 14Z344	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2 Date/Time Prepared: 1/18/2012 10:36 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)	481,551	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)	208,331	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	627	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)	689,882	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	689,882	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)	689,882	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,160	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)	678,722	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	678,722	0	19.00
20.00	Interim payments	654,191	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)	24,531	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: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/18/2012 10:36 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,293,714	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,293,714	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)	2,316,651	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,316,651	19.00
20.00	Deductibles (exclude professional component)	448,160	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)	1,868,491	22.00
23.00	Coinsurance	3,057	23.00
24.00	Subtotal (line 22 minus line 23)	1,865,434	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	82,975	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	82,975	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	74,403	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))	1,948,409	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,948,409	30.00
31.00	Interim payments	1,917,212	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)	31,197	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G | Date/Time Prepared: 1/18/2012 10:36 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	1,044,138	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	4,086,521	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,405,607	0	0	0	6.00
7.00	Inventory	270,308	0	0	0	7.00
8.00	Prepaid expenses	116,762	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,112,122	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	20,150	0	0	0	12.00
13.00	Land improvements	353,171	0	0	0	13.00
14.00	Accumulated depreciation	-173,054	0	0	0	14.00
15.00	Buildings	5,203,377	0	0	0	15.00
16.00	Accumulated depreciation	-2,797,287	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	497,869	0	0	0	19.00
20.00	Accumulated depreciation	-344,486	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	4,542,125	0	0	0	23.00
24.00	Accumulated depreciation	-3,827,914	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)	3,473,951	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2	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)	2	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	6,586,075	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	836,698	0	0	0	37.00
38.00	Salaries, wages, and fees payable	400,576	0	0	0	38.00
39.00	Payroll taxes payable	68,524	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	459,114	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,764,912	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	358,657	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	358,657	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,123,569	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,462,506				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)	4,462,506	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,586,075	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/18/2012 10:36 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		4,209,201		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		253,305				2.00
3.00	Total (sum of line 1 and line 2)		4,462,506		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,462,506		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)		4,462,506		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/18/2012 10:36 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 1/18/2012 10:36 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,716,762		1,716,762	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	195,721		195,721	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,912,483		1,912,483	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,912,483		1,912,483	17.00
18.00	Ancillary services	4,611,958	17,232,902	21,844,860	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	119,388	1,225,804	1,345,192	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	2,432	450,529	452,961	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)	34,180	632,617	666,797	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,680,441	19,541,852	26,222,293	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,369,189		29.00
30.00	BAD DEBT	1,251,920			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)		1,251,920		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)		13,621,109		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141344	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/18/2012 10:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	26,222,293	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,199,081	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,023,212	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,621,109	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-597,897	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	5,148	6.00
7.00	Income from investments	4,497	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	75,710	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	5,242	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	327,486	23.00
24.00	OTHER	433,119	24.00
25.00	Total other income (sum of lines 6-24)	851,202	25.00
26.00	Total (line 5 plus line 25)	253,305	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	253,305	29.00

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

Provider CCN: 141344 | Component CCN: 143499 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-1 | Date/Time Prepared: 1/18/2012 10:36 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	75,626	0	75,626	0	75,626	2.00
3.00	Nurse Practitioner	80,229	0	80,229	0	80,229	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	223,767	0	223,767	0	223,767	9.00
10.00	Subtotal (sum of lines 1-9)	379,622	0	379,622	0	379,622	10.00
11.00	Physician Services Under Agreement	0	380,400	380,400	0	380,400	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	380,400	380,400	0	380,400	14.00
15.00	Medical Supplies	0	4,577	4,577	0	4,577	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	26,187	26,187	0	26,187	18.00
19.00	Other Health Care Costs	0	13,382	13,382	0	13,382	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	44,146	44,146	0	44,146	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	379,622	424,546	804,168	0	804,168	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	5,961	5,961	0	5,961	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	126	126	0	126	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	6,087	6,087	0	6,087	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3,564	3,564	0	3,564	29.00
30.00	Administrative Costs	0	70,261	70,261	11,312	81,573	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	73,825	73,825	11,312	85,137	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	379,622	504,458	884,080	11,312	895,392	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 1/18/2012 10:36 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	75,626		2.00
3.00	Nurse Practitioner	0	80,229		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	223,767		9.00
10.00	Subtotal (sum of lines 1-9)	0	379,622		10.00
11.00	Physician Services Under Agreement	-47,903	332,497		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	-47,903	332,497		14.00
15.00	Medical Supplies	0	4,577		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	26,187		18.00
19.00	Other Health Care Costs	0	13,382		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	44,146		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-47,903	756,265		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	5,961		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	126		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	6,087		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	3,564		29.00
30.00	Administrative Costs	0	81,573		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	85,137		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-47,903	847,489		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141344 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-2

Component CCN: 143499 | Date/Time Prepared: 1/18/2012 10:36 am

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.60	5,452	4,200	6,720		1.00
2.00	Physician Assistant	0.86	2,391	2,100	1,806		2.00
3.00	Nurse Practitioner	0.83	2,178	2,100	1,743		3.00
4.00	Subtotal (sum of lines 1-3)	3.29	10,021		10,269	10,269	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)	3.29	10,021			10,269	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)					756,265	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					6,087	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					762,352	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.992015	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					85,137	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					511,612	15.00
16.00	Total overhead (sum of lines 14 and 15)					596,749	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					596,749	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					591,984	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,348,249	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 1/18/2012 10:36 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)	1,348,249	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)	0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,348,249	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)	10,269	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)	10,269	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	131.29	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	131.29	131.29	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,846	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	373,651	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	373,651	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		271,765	16.04
16.05	Total program cost (see instructions)	0	271,765	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		33,945	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		271,765	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		271,765	22.00
23.00	Reimbursable bad debts (see instructions)		3,009	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		274,774	26.00
27.00	Interim payments		305,727	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)		-30,953	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 1/18/2012 10:36 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		289,827	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		01/21/2011	15,900	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)		15,900	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		305,727	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		30,953	6.02
7.00	Total Medicare program liability (see instructions)		274,774	7.00

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