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: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet S Parts I-III Date/Time Prepared: 1/10/2012 8:09 am

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 1/10/2012 Time: 8:09 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 CARLINVILLE AREA HOSPITAL for the cost reporting period beginning 08/01/2010 and ending 07/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	121,466	344,267	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	112,924	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		0		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	234,390	344,267	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: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet S-2 Part I Date/Time Prepared: 1/9/2012 10:06 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 20733 NORTH BROAD STREET	PO Box:			1.00
2.00	City: CARLINVILLE	State: IL	Zip Code: 62626-	County: MACOUPIN	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	CARLINVILLE AREA HOSPITAL	141347	99914	1	07/01/2005	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	CARLINVILLE AREA HOSPITAL SWING BED	14Z347	99914		07/01/2005	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	HOSPITAL-BASED HHA	147249	99914		01/05/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC						N	N	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	08/01/2010	07/31/2011	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet S-2 Part I Date/Time Prepared: 1/9/2012 10:06 am

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

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet S-2 Part I Date/Time Prepared: 1/9/2012 10:06 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet S-2 Part I Date/Time Prepared: 1/9/2012 10:06 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.	N	N	N	N	109.00

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	2		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.	3,000,000	0	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet S-2 Part I Date/Time Prepared: 1/9/2012 10:06 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	Y	Y	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: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet S-2 Part II Date/Time Prepared: 1/9/2012 10:06 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	11/23/2011	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A			
		Description	Y/N	Date		
		0	1.00	2.00		
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	11/18/2011		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet S-2 Part II Date/Time Prepared: 1/9/2012 10:06 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.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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.					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.				Y	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: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet S-2 Part II Date/Time Prepared: 1/9/2012 10:06 am

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/18/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/9/2012 10:06 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	52,402.00		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	52,402.00		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	52,402.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			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
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: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/9/2012 10:06 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	1,825	131	2,188		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	1,665	0	1,665		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	17		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,490	131	3,870		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	3,490	131	3,870		14.00
15.00	CAH visits	0	12,353	4,844	27,246		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE		0	0	0		24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0		25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0		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		0	139		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				15		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: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/9/2012 10:06 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	458	1.00
2.00	HMO					0	2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	127.92	0.00	0	458	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00	0.00	0.00			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	0.00	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	127.92	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/9/2012 10:06 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)	40	575		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)	40	575		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
25.10	CMHC - CORF				25.10
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet S-10 Date/Time Prepared: 1/9/2012 10:06 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)	0.523538	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	660,520	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	829,238	5.00
6.00	Medicaid charges	5,086,540	6.00
7.00	Medicaid cost (line 1 times line 6)	2,662,997	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)	1,173,239	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	82,871	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,173,239	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	556,288	0	556,288	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	291,238	0	291,238	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	291,238	0	291,238	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?		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)	1,178,131	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	316,975	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	861,156	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	450,848	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	742,086	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,915,325	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A | Date/Time Prepared: 1/9/2012 10:06 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		1,340,502	1,340,502	1,609,683	2,950,185	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		702,643	702,643	14,970	717,613	2.00
3.00	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	EMPLOYEE BENEFITS	0	1,407,337	1,407,337	-858,352	548,985	4.00
5.00	ADMINISTRATIVE & GENERAL	1,047,746	1,761,226	2,808,972	75,663	2,884,635	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	196,330	538,543	734,873	28,820	763,693	7.00
8.00	LAUNDRY & LINEN SERVICE	0	61,272	61,272	0	61,272	8.00
9.00	HOUSEKEEPING	167,127	40,474	207,601	35,277	242,878	9.00
10.00	DIETARY	134,975	211,355	346,330	23,813	370,143	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	331,869	7,919	339,788	37,053	376,841	13.00
16.00	MEDICAL RECORDS & LIBRARY	204,016	161,190	365,206	24,434	389,640	16.00
19.00	NONPHYSICIAN ANESTHETISTS	190,099	25,678	215,777	13,974	229,751	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	872,336	379,782	1,252,118	125,384	1,377,502	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	197,108	233,517	430,625	18,051	448,676	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	390,067	659,326	1,049,393	63,063	1,112,456	54.00
60.00	LABORATORY	515,347	554,878	1,070,225	70,718	1,140,943	60.00
65.00	RESPIRATORY THERAPY	170,314	43,064	213,378	26,544	239,922	65.00
66.00	PHYSICAL THERAPY	390,032	47,199	437,231	56,709	493,940	66.00
67.00	OCCUPATIONAL THERAPY	93,218	801	94,019	11,620	105,639	67.00
69.00	ELECTROCARDIOLOGY	38,970	1,228	40,198	7,436	47,634	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	72,120	180,080	252,200	14,617	266,817	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	211,969	861,289	1,073,258	25,335	1,098,593	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	114,017	44,745	158,762	21,395	180,157	90.00
91.00	EMERGENCY	793,745	1,538,327	2,332,072	-308,265	2,023,807	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	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
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		1,563,171	1,563,171	-1,563,171	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,131,405	12,365,546	18,496,951	-425,229	18,071,722	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	201,384	8,211	209,595	391,025	600,620	192.00
194.00	NONREIMBURSABLE COSTS CENTERS	0	0	0	26,517	26,517	194.00
194.01	FUND DEVELOPMENT	21,096	2,735	23,831	7,687	31,518	194.01
200.00	TOTAL (SUM OF LINES 118-199)	6,353,885	12,376,492	18,730,377	0	18,730,377	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A | Date/Time Prepared: 1/9/2012 10:06 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	-92,861	2,857,324		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	717,613		2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	EMPLOYEE BENEFITS	-293,202	255,783		4.00
5.00	ADMINISTRATIVE & GENERAL	-110,092	2,774,543		5.00
6.00	MAINTENANCE & REPAIRS	0	0		6.00
7.00	OPERATION OF PLANT	-95	763,598		7.00
8.00	LAUNDRY & LINEN SERVICE	0	61,272		8.00
9.00	HOUSEKEEPING	0	242,878		9.00
10.00	DIETARY	-49,238	320,905		10.00
11.00	CAFETERIA	0	0		11.00
13.00	NURSING ADMINISTRATION	0	376,841		13.00
16.00	MEDICAL RECORDS & LIBRARY	-4,265	385,375		16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	229,751		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,377,502		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-2,545	446,131		50.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-6,129	1,106,327		54.00
60.00	LABORATORY	-1,136	1,139,807		60.00
65.00	RESPIRATORY THERAPY	0	239,922		65.00
66.00	PHYSICAL THERAPY	-463	493,477		66.00
67.00	OCCUPATIONAL THERAPY	0	105,639		67.00
69.00	ELECTROCARDIOLOGY	0	47,634		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	266,817		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	-15,801	1,082,792		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	-12,883	167,274		90.00
91.00	EMERGENCY	-932,971	1,090,836		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	0		95.00
99.10	CORF	0	0		99.10
101.00	HOME HEALTH AGENCY	0	0		101.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
116.00	HOSPICE	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,521,681	16,550,041		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	600,620		192.00
194.00	NONREIMBURSABLE COSTS CENTERS	0	26,517		194.00
194.01	FUND DEVELOPMENT	0	31,518		194.01
200.00	TOTAL (SUM OF LINES 118-199)	-1,521,681	17,208,696		200.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-6 | Date/Time Prepared: 1/9/2012 10:06 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS PHYSICIAN SURGEON EXPENSES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	313,775	52,552		1.00
	TOTALS		313,775	52,552		
	B - RECLASS NONREIMBURSEABLE COSTS					
1.00	NONREIMBURSABLE COSTS CENTERS	194.00	0	26,517		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	26,517		
	C - INSURANCE EXPENSE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	86,963		1.00
	TOTALS		0	86,963		
	E - INTEREST EXPENSE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,405		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,905		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,559,861		3.00
	TOTALS		0	1,563,171		
	F - RECLASS SALARIES FOR B-1 EMPL BEN					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	123		1.00
	TOTALS		0	123		
	H - DIRECTLY ASSIGN FICA					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	84,486		1.00
2.00	OPERATION OF PLANT	7.00	0	15,306		2.00
3.00	HOUSEKEEPING	9.00	0	12,754		3.00
4.00	DIETARY	10.00	0	10,299		4.00
5.00	NURSING ADMINISTRATION	13.00	0	28,044		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	15,425		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	66,825		7.00
8.00	OPERATING ROOM	50.00	0	13,546		8.00
9.00	NONPHYSICIAN ANESTHETISTS	19.00	0	9,469		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,626		10.00
11.00	LABORATORY	60.00	0	39,186		11.00
12.00	RESPIRATORY THERAPY	65.00	0	13,030		12.00
13.00	PHYSICAL THERAPY	66.00	0	29,682		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	7,115		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	2,931		15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,608		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,326		17.00
18.00	CLINIC	90.00	0	12,386		18.00
19.00	EMERGENCY	91.00	0	35,539		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,689		20.00
21.00	FUND DEVELOPMENT	194.01	0	3,182		21.00
	TOTALS		0	466,454		
	I - DIRECTLY ASSIGN HEALTH INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	81,081		1.00
2.00	OPERATION OF PLANT	7.00	0	13,514		2.00
3.00	HOUSEKEEPING	9.00	0	22,523		3.00
4.00	DIETARY	10.00	0	13,514		4.00
5.00	NURSING ADMINISTRATION	13.00	0	9,009		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	9,009		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	58,559		7.00
8.00	OPERATING ROOM	50.00	0	4,505		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,532		9.00
10.00	LABORATORY	60.00	0	31,532		10.00
11.00	RESPIRATORY THERAPY	65.00	0	13,514		11.00
12.00	PHYSICAL THERAPY	66.00	0	27,027		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	4,505		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,009		14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,009		15.00
16.00	CLINIC	90.00	0	9,009		16.00
17.00	EMERGENCY	91.00	0	22,523		17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,009		18.00
19.00	FUND DEVELOPMENT	194.01	0	4,505		19.00
20.00	NONPHYSICIAN ANESTHETISTS	19.00	0	4,505		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	4,505		21.00
	TOTALS		0	391,898		
500.00	Grand Total: Increases		313,775	2,587,678		500.00

RECLASSIFICATIONS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-6 | Date/Time Prepared: 1/9/2012 10:06 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS PHYSICIAN SURGEON EXPENSES						
1.00	EMERGENCY	91.00	313,775	52,552	0		1.00
	TOTALS		313,775	52,552			
	B - RECLASS NONREIMBURSEABLE COSTS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	22,171	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4,346	0		2.00
	TOTALS		0	26,517			
	C - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	86,963	0		1.00
	TOTALS		0	86,963			
	E - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	1,563,171	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	1,563,171			
	F - RECLASS SALARIES FOR B-1 EMPL BEN						
1.00	ADMINISTRATIVE & GENERAL	5.00	123	0	0		1.00
	TOTALS		123	0			
	H - DIRECTLY ASSIGN FICA						
1.00	EMPLOYEE BENEFITS	4.00	0	466,454	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
	TOTALS		0	466,454			
	I - DIRECTLY ASSIGN HEALTH INSURANCE						
1.00	EMPLOYEE BENEFITS	4.00	0	391,898	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
	TOTALS		0	391,898			
500.00	Grand Total: Decreases		313,898	2,587,555			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/9/2012 10:06 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	602,527	0	0	0	0	1.00
2.00	Land Improvements	373,103	1,245,709	0	1,245,709	298,793	2.00
3.00	Buildings and Fixtures	29,927,461	0	0	0	9,427,691	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,534,825	2,964,273	0	2,964,273	2,836,798	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,437,916	4,209,982	0	4,209,982	12,563,282	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,437,916	4,209,982	0	4,209,982	12,563,282	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,340,502	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	702,643	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,043,145	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	22,422,316	0	22,422,316	0.827862	71,993	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,662,300	0	4,662,300	0.172138	14,970	2.00
3.00	Total (sum of lines 1-2)	27,084,616	0	27,084,616	1.000000	86,963	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/9/2012 10:06 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	602,527	0				1.00
2.00	Land Improvements	1,320,019	0				2.00
3.00	Buildings and Fixtures	20,499,770	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4,662,300	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	27,084,616	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	27,084,616	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	1,340,502				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	702,643				2.00
3.00	Total (sum of lines 1-2)	0	2,043,145				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	71,993	2,785,331	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	14,970	702,643	0	2.00
3.00	Total (sum of lines 1-2)	0	0	86,963	3,487,974	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/9/2012 10:06 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	71,993	0	0	2,857,324	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	14,970	0	0	717,613	2.00
3.00	Total (sum of lines 1-2)	0	86,963	0	0	3,574,937	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-8 | Date/Time Prepared: 1/9/2012 10:06 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - buildings and fixtures (chapter 2)	B	-80,739	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-4,144	ADMINISTRATIVE & GENERAL	5.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,313	ADMINISTRATIVE & GENERAL	5.00	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	-932,971			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	-45,613	DIETARY	10.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients	B	-15,801	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00	Sale of medical records and abstracts	B	-4,265	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	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	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	DIETARY DISCOUNTS	B	-3,625	DIETARY	10.00	33.00
33.01	RADIOLOGY DISCOUNTS	B	-6,129	RADIOLOGY-DIAGNOSTIC	54.00	33.01
33.02	PT PROF FEES	B	-463	PHYSICAL THERAPY	66.00	33.02
33.03	DOMESTIC CHARGES OFFSET	A	-293,202	EMPLOYEE BENEFITS	4.00	33.03
33.04	CONTRACT LAB	B	-1,036	LABORATORY	60.00	33.04
33.05	SUPPLIES	B	-2,545	OPERATING ROOM	50.00	33.05
33.06	AHA DUES	A	-732	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07			0		0.00	33.07
36.00	TELEVISION DEPRECIATION	A	-9,909	NEW CAP REL COSTS-BLDG & FIXT	1.00	36.00
37.00	LOBBYING COSTS	A	-4,746	ADMINISTRATIVE & GENERAL	5.00	37.00
39.00	MED STAFF RELATIONS	A	-1,692	ADMINISTRATIVE & GENERAL	5.00	39.00
40.00	EMPLOYEE CHRISTMAS	A	-1,366	ADMINISTRATIVE & GENERAL	5.00	40.00
41.00			0		0.00	41.00
42.00	ADVERTISING	A	-74,705	ADMINISTRATIVE & GENERAL	5.00	42.00
44.00	TELEPHONE DEPRECIATION	A	-2,213	NEW CAP REL COSTS-BLDG & FIXT	1.00	44.00
44.01	TELEPHONE TRUNKLINE CHARGES	A	-7,386	ADMINISTRATIVE & GENERAL	5.00	44.01
44.02	SPRINGFIELD CLINIC RENT	B	-12,883	CLINIC	90.00	44.02
44.03	PATIENT TELEVISION OFFSET	A	-2,774	ADMINISTRATIVE & GENERAL	5.00	44.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-8 | Date/Time Prepared: 1/9/2012 10:06 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	
44.04			0		0.00	44.04
44.05			0		0.00	44.05
44.06			0		0.00	44.06
44.07	PROP TAXES-POGUE BLDG	A	-861	ADMINISTRATIVE & GENERAL	5.00	44.07
45.00	PHYSICIAN RECRUITMENT	A	-7,250	ADMINISTRATIVE & GENERAL	5.00	45.00
45.01	PLANT OPERATIONS DISCOUNTS	B	-95	OPERATION OF PLANT	7.00	45.01
45.02	LAB DISCOUNTS	B	-100	LABORATORY	60.00	45.02
45.03	RECORD REVIEW COSTS	A	-123	ADMINISTRATIVE & GENERAL	5.00	45.03
45.04			0		0.00	45.04
45.05			0		0.00	45.05
45.06			0		0.00	45.06
45.07			0		0.00	45.07
45.08			0		0.00	45.08
45.09			0		0.00	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,521,681			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-8 | Date/Time Prepared: 1/9/2012 10:06 am

		Wkst. A-7 Ref. 5.00		
1.00	Investment income - buildings and fixtures (chapter 2)	9		1.00
2.00	Investment income - movable equipment (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - buildings and fixtures	0		26.00
27.00	Depreciation - movable equipment	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	DIETARY DISCOUNTS	0		33.00
33.01	RADIOLOGY DISCOUNTS	0		33.01
33.02	PT PROF FEES	0		33.02
33.03	DOMESTIC CHARGES OFFSET	0		33.03
33.04	CONTRACT LAB	0		33.04
33.05	SUPPLIES	0		33.05
33.06	AHA DUES	0		33.06
33.07		0		33.07
36.00	TELEVISION DEPRECIATION	9		36.00
37.00	LOBBYING COSTS	0		37.00
39.00	MED STAFF RELATIONS	0		39.00
40.00	EMPLOYEE CHRISTMAS	0		40.00
41.00		0		41.00
42.00	ADVERTISING	0		42.00
44.00	TELEPHONE DEPRECIATION	9		44.00
44.01	TELEPHONE TRUNKLINE CHARGES	0		44.01
44.02	SPRINGFIELD CLINIC RENT	0		44.02
44.03	PATIENT TELEVISION OFFSET	0		44.03
44.04		0		44.04
44.05		0		44.05
44.06		0		44.06
44.07	PROP TAXES-POGUE BLDG	0		44.07
45.00	PHYSICIAN RECRUITMENT	0		45.00
45.01	PLANT OPERATIONS DISCOUNTS	0		45.01
45.02	LAB DISCOUNTS	0		45.02
45.03	RECORD REVIEW COSTS	0		45.03
45.04		0		45.04
45.05		0		45.05

ADJUSTMENTS TO EXPENSES	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet A-8 Date/Time Prepared: 1/9/2012 10:06 am

		Wkst. A-7 Ref. 5.00		
45.06		0		45.06
45.07		0		45.07
45.08		0		45.08
45.09		0		45.09
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: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/9/2012 10:06 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	1,361,321	932,971	1.00
2.00		0.00		0	0	2.00
3.00		0.00		0	0	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00			TOTAL (lines 1.00 through 199.00)	1,361,321	932,971	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/9/2012 10:06 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		428,350	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		428,350		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/9/2012 10:06 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: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/9/2012 10:06 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	932,971		1.00
2.00		0	0		2.00
3.00		0	0		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	932,971		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B Part I Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,857,324	2,857,324				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	717,613		717,613			2.00
4.00	EMPLOYEE BENEFITS	255,783	0	0	255,783		4.00
5.00	ADMINISTRATIVE & GENERAL	2,774,543	577,473	152,788	42,173	3,546,977	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	763,598	399,149	28,344	7,904	1,198,995	7.00
8.00	LAUNDRY & LINEN SERVICE	61,272	0	0	0	61,272	8.00
9.00	HOUSEKEEPING	242,878	18,673	18	6,728	268,297	9.00
10.00	DIETARY	320,905	71,890	17,036	5,434	415,265	10.00
11.00	CAFETERIA	0	72,441	0	0	72,441	11.00
13.00	NURSING ADMINISTRATION	376,841	11,865	636	13,360	402,702	13.00
16.00	MEDICAL RECORDS & LIBRARY	385,375	53,517	8,038	8,213	455,143	16.00
19.00	NONPHYSICIAN ANESTHETISTS	229,751	3,955	35	7,653	241,394	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,377,502	561,102	38,931	35,118	2,012,653	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	446,131	263,329	64,894	7,935	782,289	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,106,327	176,821	331,058	15,703	1,629,909	54.00
60.00	LABORATORY	1,139,807	73,742	10,697	20,746	1,244,992	60.00
65.00	RESPIRATORY THERAPY	239,922	97,622	9,039	6,856	353,439	65.00
66.00	PHYSICAL THERAPY	493,477	142,829	9,065	15,702	661,073	66.00
67.00	OCCUPATIONAL THERAPY	105,639	8,711	0	3,753	118,103	67.00
69.00	ELECTROCARDIOLOGY	47,634	0	7,559	1,569	56,762	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	266,817	41,402	1,130	2,903	312,252	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,082,792	32,240	7,009	8,533	1,130,574	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	167,274	97,222	2,846	4,590	271,932	90.00
91.00	EMERGENCY	1,090,836	110,538	28,118	19,322	1,248,814	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	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
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,550,041	2,814,521	717,241	234,195	16,485,278	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,161	19	0	9,180	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	600,620	30,588	53	20,739	652,000	192.00
194.00	NONREIMBURSABLE COSTS CENTERS	26,517	0	0	0	26,517	194.00
194.01	FUND DEVELOPMENT	31,518	3,054	300	849	35,721	194.01
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)	17,208,696	2,857,324	717,613	255,783	17,208,696	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B Part I Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	3,546,977					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	311,294	0	1,510,289			7.00
8.00	LAUNDRY & LINEN SERVICE	15,908	0	0	77,180		8.00
9.00	HOUSEKEEPING	69,658	0	14,996	0	352,951	9.00
10.00	DIETARY	107,815	0	57,731	0	13,627	10.00
11.00	CAFETERIA	18,808	0	58,173	0	13,731	11.00
13.00	NURSING ADMINISTRATION	104,553	0	9,528	0	2,249	13.00
16.00	MEDICAL RECORDS & LIBRARY	118,168	0	42,977	0	10,144	16.00
19.00	NONPHYSICIAN ANESTHETISTS	62,673	0	3,176	0	750	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	522,541	0	450,591	43,528	106,357	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	203,105	0	211,465	6,874	49,915	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	423,172	0	141,995	6,827	33,517	54.00
60.00	LABORATORY	323,236	0	59,218	0	13,978	60.00
65.00	RESPIRATORY THERAPY	91,763	0	78,395	0	18,504	65.00
66.00	PHYSICAL THERAPY	171,634	0	114,698	2,803	27,073	66.00
67.00	OCCUPATIONAL THERAPY	30,663	0	6,995	0	1,651	67.00
69.00	ELECTROCARDIOLOGY	14,737	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,070	0	33,248	0	7,848	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	293,530	0	25,890	0	6,111	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	70,601	0	78,073	0	18,429	90.00
91.00	EMERGENCY	324,228	0	88,767	17,148	20,953	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	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
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,359,157	0	1,475,916	77,180	344,837	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,383	0	7,357	0	1,737	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	169,278	0	24,564	0	5,798	192.00
194.00	NONREIMBURSABLE COSTS CENTERS	6,885	0	0	0	0	194.00
194.01	FUND DEVELOPMENT	9,274	0	2,452	0	579	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,546,977	0	1,510,289	77,180	352,951	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B Part I Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		10.00	11.00	13.00	16.00	19.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
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	594,438					10.00
11.00	CAFETERIA	292,407	455,560				11.00
13.00	NURSING ADMINISTRATION	0	21,417	540,449			13.00
16.00	MEDICAL RECORDS & LIBRARY	0	32,762	0	659,194		16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	5,189	12,760	9,371	335,313	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	302,031	111,564	274,290	49,606	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	18,517	45,526	24,442	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	335,313	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	37,493	0	165,808	0	54.00
60.00	LABORATORY	0	54,891	0	119,345	0	60.00
65.00	RESPIRATORY THERAPY	0	17,093	0	22,708	0	65.00
66.00	PHYSICAL THERAPY	0	31,337	0	39,274	0	66.00
67.00	OCCUPATIONAL THERAPY	0	5,342	0	9,186	0	67.00
69.00	ELECTROCARDIOLOGY	0	3,815	0	11,625	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,818	0	29,725	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	17,551	43,151	46,468	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	14,651	36,020	7,828	0	90.00
91.00	EMERGENCY	0	52,347	128,702	73,673	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	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
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	594,438	433,787	540,449	609,059	335,313	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	18,772	0	50,135	0	192.00
194.00	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	FUND DEVELOPMENT	0	3,001	0	0	0	194.01
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)	594,438	455,560	540,449	659,194	335,313	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B Part I | Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
19.00	NONPHYSICIAN ANESTHETISTS					19.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	3,873,161	-1,939	3,871,222		30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	1,342,133	0	1,342,133		50.00
53.00	ANESTHESIOLOGY	335,313	0	335,313		53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,438,721	0	2,438,721		54.00
60.00	LABORATORY	1,815,660	1,939	1,817,599		60.00
65.00	RESPIRATORY THERAPY	581,902	0	581,902		65.00
66.00	PHYSICAL THERAPY	1,047,892	0	1,047,892		66.00
67.00	OCCUPATIONAL THERAPY	171,940	0	171,940		67.00
69.00	ELECTROCARDIOLOGY	86,939	0	86,939		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	473,961	0	473,961		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	1,563,275	0	1,563,275		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	497,534	0	497,534		90.00
91.00	EMERGENCY	1,954,632	0	1,954,632		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0	0	0		95.00
99.10	CORF	0	0	0		99.10
101.00	HOME HEALTH AGENCY	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
116.00	HOSPICE	0	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,183,063	0	16,183,063		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	20,657	0	20,657		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	920,547	0	920,547		192.00
194.00	NONREIMBURSABLE COSTS CENTERS	33,402	0	33,402		194.00
194.01	FUND DEVELOPMENT	51,027	0	51,027		194.01
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	17,208,696	0	17,208,696		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B Part II Date/Time Prepared: 1/9/2012 10:06 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
5.00	ADMINISTRATIVE & GENERAL	29,653	577,473	152,788	759,914	0	5.00
6.00	MAINTENANCE & REPAIRS	2,155	0	0	2,155	0	6.00
7.00	OPERATION OF PLANT	135	399,149	28,344	427,628	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	18,673	18	18,691	0	9.00
10.00	DIETARY	1,424	71,890	17,036	90,350	0	10.00
11.00	CAFETERIA	0	72,441	0	72,441	0	11.00
13.00	NURSING ADMINISTRATION	0	11,865	636	12,501	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	12,582	53,517	8,038	74,137	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	3,955	35	3,990	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	44,383	561,102	38,931	644,416	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	125,078	263,329	64,894	453,301	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	21,166	176,821	331,058	529,045	0	54.00
60.00	LABORATORY	61,661	73,742	10,697	146,100	0	60.00
65.00	RESPIRATORY THERAPY	1,470	97,622	9,039	108,131	0	65.00
66.00	PHYSICAL THERAPY	0	142,829	9,065	151,894	0	66.00
67.00	OCCUPATIONAL THERAPY	0	8,711	0	8,711	0	67.00
69.00	ELECTROCARDIOLOGY	0	0	7,559	7,559	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,402	1,130	42,532	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	88,760	32,240	7,009	128,009	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	150	97,222	2,846	100,218	0	90.00
91.00	EMERGENCY	1,207	110,538	28,118	139,863	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	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
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	389,824	2,814,521	717,241	3,921,586	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,161	19	9,180	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	30,588	53	30,641	0	192.00
194.00	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	FUND DEVELOPMENT	0	3,054	300	3,354	0	194.01
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)	389,824	2,857,324	717,613	3,964,761	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B Part II Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	759,914					5.00
6.00	MAINTENANCE & REPAIRS	0	2,155				6.00
7.00	OPERATION OF PLANT	66,693	377	494,698			7.00
8.00	LAUNDRY & LINEN SERVICE	3,408	0	0	3,408		8.00
9.00	HOUSEKEEPING	14,924	18	4,912	0	38,545	9.00
10.00	DIETARY	23,099	68	18,910	0	1,488	10.00
11.00	CAFETERIA	4,029	68	19,055	0	1,500	11.00
13.00	NURSING ADMINISTRATION	22,400	11	3,121	0	246	13.00
16.00	MEDICAL RECORDS & LIBRARY	25,317	51	14,077	0	1,108	16.00
19.00	NONPHYSICIAN ANESTHETISTS	13,427	4	1,040	0	82	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	111,946	531	147,593	1,922	11,614	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	43,514	249	69,266	304	5,451	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	90,662	167	46,511	301	3,660	54.00
60.00	LABORATORY	69,251	70	19,397	0	1,527	60.00
65.00	RESPIRATORY THERAPY	19,660	92	25,678	0	2,021	65.00
66.00	PHYSICAL THERAPY	36,772	135	37,569	124	2,957	66.00
67.00	OCCUPATIONAL THERAPY	6,569	8	2,291	0	180	67.00
69.00	ELECTROCARDIOLOGY	3,157	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,369	39	10,890	0	857	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	62,887	30	8,480	0	667	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	15,126	92	25,573	0	2,013	90.00
91.00	EMERGENCY	69,464	104	29,076	757	2,288	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	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
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	719,674	2,114	483,439	3,408	37,659	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	511	9	2,410	0	190	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	36,267	29	8,046	0	633	192.00
194.00	NONREIMBURSABLE COSTS CENTERS	1,475	0	0	0	0	194.00
194.01	FUND DEVELOPMENT	1,987	3	803	0	63	194.01
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)	759,914	2,155	494,698	3,408	38,545	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B Part II Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		10.00	11.00	13.00	16.00	19.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
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	133,915					10.00
11.00	CAFETERIA	65,873	162,966				11.00
13.00	NURSING ADMINISTRATION	0	7,661	45,940			13.00
16.00	MEDICAL RECORDS & LIBRARY	0	11,720	0	126,410		16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	1,856	1,085	1,797	23,281	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	68,042	39,910	23,315	9,513		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	6,624	3,870	4,687		50.00
53.00	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,412	0	31,794		54.00
60.00	LABORATORY	0	19,636	0	22,887		60.00
65.00	RESPIRATORY THERAPY	0	6,115	0	4,355		65.00
66.00	PHYSICAL THERAPY	0	11,210	0	7,532		66.00
67.00	OCCUPATIONAL THERAPY	0	1,911	0	1,762		67.00
69.00	ELECTROCARDIOLOGY	0	1,365	0	2,229		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,512	0	5,700		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	6,278	3,668	8,911		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	CLINIC	0	5,241	3,062	1,501		90.00
91.00	EMERGENCY	0	18,726	10,940	14,128		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	CORF	0	0	0	0		99.10
101.00	HOME HEALTH AGENCY	0	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0		113.00
116.00	HOSPICE	0	0	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	133,915	155,177	45,940	116,796	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	6,715	0	9,614		192.00
194.00	NONREIMBURSABLE COSTS CENTERS	0	0	0	0		194.00
194.01	FUND DEVELOPMENT	0	1,074	0	0		194.01
200.00	Cross Foot Adjustments					23,281	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	133,915	162,966	45,940	126,410	23,281	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B Part II Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
19.00	NONPHYSICIAN ANESTHETISTS					19.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	1,058,802	0	1,058,802		30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	587,266	0	587,266		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	715,552	0	715,552		54.00
60.00	LABORATORY	278,868	0	278,868		60.00
65.00	RESPIRATORY THERAPY	166,052	0	166,052		65.00
66.00	PHYSICAL THERAPY	248,193	0	248,193		66.00
67.00	OCCUPATIONAL THERAPY	21,432	0	21,432		67.00
69.00	ELECTROCARDIOLOGY	14,310	0	14,310		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,899	0	80,899		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	218,930	0	218,930		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	152,826	0	152,826		90.00
91.00	EMERGENCY	285,346	0	285,346		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0	0	0		95.00
99.10	CORF	0	0	0		99.10
101.00	HOME HEALTH AGENCY	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE	0	0	0		113.00
116.00	HOSPICE	0	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,828,476	0	3,828,476		118.00
	NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	12,300	0	12,300		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	91,945	0	91,945		192.00
194.00	NONREIMBURSABLE COSTS CENTERS	1,475	0	1,475		194.00
194.01	FUND DEVELOPMENT	7,284	0	7,284		194.01
200.00	Cross Foot Adjustments	23,281	0	23,281		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	3,964,761	0	3,964,761		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B-1 | Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	57,075					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		672,652				2.00
4.00	EMPLOYEE BENEFITS	0	0	6,353,762			4.00
5.00	ADMINISTRATIVE & GENERAL	11,535	143,215	1,047,623	-3,546,977	13,661,719	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	7,973	26,568	196,330	0	1,198,995	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	61,272	8.00
9.00	HOUSEKEEPING	373	17	167,127	0	268,297	9.00
10.00	DIETARY	1,436	15,969	134,975	0	415,265	10.00
11.00	CAFETERIA	1,447	0	0	0	72,441	11.00
13.00	NURSING ADMINISTRATION	237	596	331,869	0	402,702	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,069	7,534	204,016	0	455,143	16.00
19.00	NONPHYSICIAN ANESTHETISTS	79	33	190,099	0	241,394	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,208	36,492	872,336	0	2,012,653	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,260	60,828	197,108	0	782,289	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,532	310,316	390,067	0	1,629,909	54.00
60.00	LABORATORY	1,473	10,027	515,347	0	1,244,992	60.00
65.00	RESPIRATORY THERAPY	1,950	8,473	170,314	0	353,439	65.00
66.00	PHYSICAL THERAPY	2,853	8,497	390,032	0	661,073	66.00
67.00	OCCUPATIONAL THERAPY	174	0	93,218	0	118,103	67.00
69.00	ELECTROCARDIOLOGY	0	7,085	38,970	0	56,762	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	1,059	72,120	0	312,252	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	644	6,570	211,969	0	1,130,574	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	1,942	2,668	114,017	0	271,932	90.00
91.00	EMERGENCY	2,208	26,356	479,970	0	1,248,814	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	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
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	56,220	672,303	5,817,507	-3,546,977	12,938,301	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	18	0	0	9,180	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	611	50	515,159	0	652,000	192.00
194.00	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	26,517	194.00
194.01	FUND DEVELOPMENT	61	281	21,096	0	35,721	194.01
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)	2,857,324	717,613	255,783		3,546,977	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	50.062619	1.066841	0.040257		0.259629	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		759,914	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.055624	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B-1 | Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	45,540					6.00
7.00	OPERATION OF PLANT	7,973	37,567				7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	103,742			8.00
9.00	HOUSEKEEPING	373	373	0	37,194		9.00
10.00	DIETARY	1,436	1,436	0	1,436	35,887	10.00
11.00	CAFETERIA	1,447	1,447	0	1,447	17,653	11.00
13.00	NURSING ADMINISTRATION	237	237	0	237	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,069	1,069	0	1,069	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	79	79	0	79	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,208	11,208	58,508	11,208	18,234	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,260	5,260	9,240	5,260	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,532	3,532	9,177	3,532	0	54.00
60.00	LABORATORY	1,473	1,473	0	1,473	0	60.00
65.00	RESPIRATORY THERAPY	1,950	1,950	0	1,950	0	65.00
66.00	PHYSICAL THERAPY	2,853	2,853	3,768	2,853	0	66.00
67.00	OCCUPATIONAL THERAPY	174	174	0	174	0	67.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	827	827	0	827	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	644	644	0	644	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	1,942	1,942	0	1,942	0	90.00
91.00	EMERGENCY	2,208	2,208	23,049	2,208	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	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
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	44,685	36,712	103,742	36,339	35,887	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	183	183	0	183	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	611	611	0	611	0	192.00
194.00	NONREIMBURSABLE COSTS CENTERS	0	0	0	0	0	194.00
194.01	FUND DEVELOPMENT	61	61	0	61	0	194.01
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	1,510,289	77,180	352,951	594,438	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	40.202545	0.743961	9.489461	16.564160	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,155	494,698	3,408	38,545	133,915	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.047321	13.168419	0.032851	1.036323	3.731574	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B-1 | Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		11.00	13.00	16.00	19.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
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	8,955					11.00
13.00	NURSING ADMINISTRATION	421	89,876				13.00
16.00	MEDICAL RECORDS & LIBRARY	644	0	34,165,879			16.00
19.00	NONPHYSICIAN ANESTHETISTS	102	2,122	485,690	100		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,193	45,614	2,571,082			30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	364	7,571	1,266,802	0		50.00
53.00	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	RADIOLOGY-DIAGNOSTIC	737	0	8,593,830	0		54.00
60.00	LABORATORY	1,079	0	6,185,585	0		60.00
65.00	RESPIRATORY THERAPY	336	0	1,176,953	0		65.00
66.00	PHYSICAL THERAPY	616	0	2,035,551	0		66.00
67.00	OCCUPATIONAL THERAPY	105	0	476,105	0		67.00
69.00	ELECTROCARDIOLOGY	75	0	602,537	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	193	0	1,540,644	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	345	7,176	2,408,438	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	CLINIC	288	5,990	405,737	0		90.00
91.00	EMERGENCY	1,029	21,403	3,818,447	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	CORF	0	0	0	0		99.10
101.00	HOME HEALTH AGENCY	0	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0		113.00
116.00	HOSPICE	0	0	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,527	89,876	31,567,401	100		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	369	0	2,598,478	0		192.00
194.00	NONREIMBURSABLE COSTS CENTERS	0	0	0	0		194.00
194.01	FUND DEVELOPMENT	59	0	0	0		194.01
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)	455,560	540,449	659,194	335,313		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	50.872138	6.013274	0.019294	3,353.130000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	162,966	45,940	126,410	23,281		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	18.198325	0.511149	0.003700	232.810000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet B-2 | Date/Time Prepared: 1/9/2012 10:06 am

		Description	Worksheet Part	Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		LABORATORY	1	60.00	1,939	5.00
6.00		ADULTS AND PEDIATRICS	1	30.00	-1,939	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet C Part I Date/Time Prepared: 1/9/2012 10:06 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	3,871,222		3,871,222	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,342,133		1,342,133	0	0	50.00
53.00	ANESTHESIOLOGY	335,313		335,313	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,438,721		2,438,721	0	0	54.00
60.00	LABORATORY	1,817,599		1,817,599	0	0	60.00
65.00	RESPIRATORY THERAPY	581,902	0	581,902	0	0	65.00
66.00	PHYSICAL THERAPY	1,047,892	0	1,047,892	0	0	66.00
67.00	OCCUPATIONAL THERAPY	171,940	0	171,940	0	0	67.00
69.00	ELECTROCARDIOLOGY	86,939		86,939	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	473,961		473,961	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,563,275		1,563,275	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	497,534		497,534	0	0	90.00
91.00	EMERGENCY	1,954,632		1,954,632	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	134,723		134,723		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0		0	0	0	95.00
99.10	CORF	0		0		0	99.10
101.00	HOME HEALTH AGENCY	0		0		0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0		0		0	116.00
200.00	Subtotal (see instructions)	16,317,786	0	16,317,786	0	0	200.00
201.00	Less Observation Beds	134,723		134,723		0	201.00
202.00	Total (see instructions)	16,183,063	0	16,183,063	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet C Part I Date/Time Prepared: 1/9/2012 10:06 am

Title XVIII | Hospital | Cost

	Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,434,558		2,434,558			30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	74,554	1,160,469	1,235,023	1.086727	0.000000	50.00
53.00	ANESTHESIOLOGY	22,879	461,587	484,466	0.692129	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	764,262	7,684,360	8,448,622	0.288653	0.000000	54.00
60.00	LABORATORY	1,002,295	5,088,861	6,091,156	0.298400	0.000000	60.00
65.00	RESPIRATORY THERAPY	297,636	863,051	1,160,687	0.501343	0.000000	65.00
66.00	PHYSICAL THERAPY	454,218	1,561,992	2,016,210	0.519734	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	294,528	181,018	475,546	0.361563	0.000000	67.00
69.00	ELECTROCARDIOLOGY	43,134	546,379	589,513	0.147476	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	764,605	765,053	1,529,658	0.309848	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	1,248,270	1,141,008	2,389,278	0.654288	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	1,863	400,079	401,942	1.237825	0.000000	90.00
91.00	EMERGENCY	67,524	3,720,020	3,787,544	0.516068	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	5,043	119,046	124,089	1.085697	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.10	CORF	0	0	0			99.10
101.00	HOME HEALTH AGENCY	0	0	0			101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	7,475,369	23,692,923	31,168,292			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	7,475,369	23,692,923	31,168,292			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet C Part I Date/Time Prepared: 1/9/2012 10:06 am

Title XVIII | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio	
		11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	ADULTS & PEDIATRICS		30.00
	ANCILLARY SERVICE COST CENTERS		
50.00	OPERATING ROOM	0.000000	50.00
53.00	ANESTHESIOLOGY	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	LABORATORY	0.000000	60.00
65.00	RESPIRATORY THERAPY	0.000000	65.00
66.00	PHYSICAL THERAPY	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	ELECTROCARDIOLOGY	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS		
88.00	RURAL HEALTH CLINIC		88.00
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
	OTHER REIMBURSABLE COST CENTERS		
95.00	AMBULANCE SERVICES	0.000000	95.00
99.10	CORF		99.10
101.00	HOME HEALTH AGENCY		101.00
	SPECIAL PURPOSE COST CENTERS		
113.00	INTEREST EXPENSE		113.00
116.00	HOSPICE		116.00
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: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D Part II Date/Time Prepared: 1/9/2012 10:06 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	587,266	1,235,023	0.475510	35,585	16,921	50.00
53.00	ANESTHESIOLOGY	0	484,466	0.000000	11,549	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	715,552	8,448,622	0.084695	529,137	44,815	54.00
60.00	LABORATORY	278,868	6,091,156	0.045782	664,832	30,437	60.00
65.00	RESPIRATORY THERAPY	166,052	1,160,687	0.143064	159,875	22,872	65.00
66.00	PHYSICAL THERAPY	248,193	2,016,210	0.123099	126,611	15,586	66.00
67.00	OCCUPATIONAL THERAPY	21,432	475,546	0.045068	57,093	2,573	67.00
69.00	ELECTROCARDIOLOGY	14,310	589,513	0.024274	30,759	747	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,899	1,529,658	0.052887	419,552	22,189	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	218,930	2,389,278	0.091630	647,039	59,288	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	152,826	401,942	0.380219	663	252	90.00
91.00	EMERGENCY	285,346	3,787,544	0.075338	22,874	1,723	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	124,089	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	2,769,674	28,733,734		2,705,569	217,403	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D Part IV Date/Time Prepared: 1/9/2012 10:06 am

Title XVIII | Hospital | Cost

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	335,313	0	0	0	335,313	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
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
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	335,313	0	0	0	335,313	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D Part IV Date/Time Prepared: 1/9/2012 10:06 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	1,235,023	0.000000	0.000000	35,585	50.00
53.00	ANESTHESIOLOGY	0	484,466	0.692129	0.000000	11,549	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,448,622	0.000000	0.000000	529,137	54.00
60.00	LABORATORY	0	6,091,156	0.000000	0.000000	664,832	60.00
65.00	RESPIRATORY THERAPY	0	1,160,687	0.000000	0.000000	159,875	65.00
66.00	PHYSICAL THERAPY	0	2,016,210	0.000000	0.000000	126,611	66.00
67.00	OCCUPATIONAL THERAPY	0	475,546	0.000000	0.000000	57,093	67.00
69.00	ELECTROCARDIOLOGY	0	589,513	0.000000	0.000000	30,759	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,529,658	0.000000	0.000000	419,552	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	2,389,278	0.000000	0.000000	647,039	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	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	401,942	0.000000	0.000000	663	90.00
91.00	EMERGENCY	0	3,787,544	0.000000	0.000000	22,874	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	124,089	0.000000	0.000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	28,733,734			2,705,569	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D Part IV Date/Time Prepared: 1/9/2012 10:06 am

Title XVIII | Hospital | Cost

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
53.00	ANESTHESIOLOGY	7,993	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
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
	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
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	7,993	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D Part V Date/Time Prepared: 1/9/2012 10:06 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	1.086727	0	722,980	0		50.00
53.00	ANESTHESIOLOGY	0.692129	0	288,945	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.288653	0	3,463,522	0		54.00
60.00	LABORATORY	0.298400	0	2,656,129	0		60.00
65.00	RESPIRATORY THERAPY	0.501343	0	184,989	0		65.00
66.00	PHYSICAL THERAPY	0.519734	0	545,443	0		66.00
67.00	OCCUPATIONAL THERAPY	0.361563	0	49,780	0		67.00
69.00	ELECTROCARDIOLOGY	0.147476	0	354,592	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.309848	0	428,338	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.654288	0	618,969	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	1.237825	0	180,659	0		90.00
91.00	EMERGENCY	0.516068	0	1,441,902	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.085697	0	59,013	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.000000		0			95.00
200.00	Subtotal (see instructions)		0	10,995,261	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	10,995,261	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D Part V Date/Time Prepared: 1/9/2012 10:06 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	785,682	0		50.00
53.00	ANESTHESIOLOGY	0	199,987	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	999,756	0		54.00
60.00	LABORATORY	0	792,589	0		60.00
65.00	RESPIRATORY THERAPY	0	92,743	0		65.00
66.00	PHYSICAL THERAPY	0	283,485	0		66.00
67.00	OCCUPATIONAL THERAPY	0	17,999	0		67.00
69.00	ELECTROCARDIOLOGY	0	52,294	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	132,720	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	404,984	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	223,624	0		90.00
91.00	EMERGENCY	0	744,119	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	64,070	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	4,794,052	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	4,794,052	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D Part V | Date/Time Prepared: 1/9/2012 10:06 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	1.086727	0	0	0		50.00
53.00	ANESTHESIOLOGY	0.692129	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.288653	0	0	0		54.00
60.00	LABORATORY	0.298400	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0.501343	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.519734	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0.361563	0	0	0		67.00
69.00	ELECTROCARDIOLOGY	0.147476	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.309848	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	0.654288	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	1.237825	0	0	0		90.00
91.00	EMERGENCY	0.516068	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.085697	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.000000		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: 141347 | Component CCN: 14Z347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D Part V | Date/Time Prepared: 1/9/2012 10:06 am

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
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
	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
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet D-1 Date/Time Prepared: 1/9/2012 10:06 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)	4,009	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,327	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)	2,327	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	694	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)	971	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	10	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,825	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)	694	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)	971	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	118.65	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	119.84	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,871,222	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)	831	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)	1,198	25.00
26.00	Total swing-bed cost (see instructions)	1,615,814	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,255,408	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,812,354	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,812,354	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.244463	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)	778.84	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,255,408	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)	969.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,768,863	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)	1,768,863	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D-1 | Date/Time Prepared: 1/9/2012 10:06 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)	1,134,895	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,903,758	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)	672,653	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	941,132	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,613,785	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)	139	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	969.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	134,723	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet D-1 Date/Time Prepared: 1/9/2012 10:06 am
	Title XVIII	Hospital	Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet D-3 Date/Time Prepared: 1/9/2012 10:06 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		1,358,308		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	1.086727	35,585	38,671	50.00
53.00	ANESTHESIOLOGY	0.692129	11,549	7,993	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.288653	529,137	152,737	54.00
60.00	LABORATORY	0.298400	664,832	198,386	60.00
65.00	RESPIRATORY THERAPY	0.501343	159,875	80,152	65.00
66.00	PHYSICAL THERAPY	0.519734	126,611	65,804	66.00
67.00	OCCUPATIONAL THERAPY	0.361563	57,093	20,643	67.00
69.00	ELECTROCARDIOLOGY	0.147476	30,759	4,536	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.309848	419,552	129,997	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.654288	647,039	423,350	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	1.237825	663	821	90.00
91.00	EMERGENCY	0.516068	22,874	11,805	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.085697	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		2,705,569	1,134,895	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)		2,705,569		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141347 | Component CCN: 14Z347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet D-3 | Date/Time Prepared: 1/9/2012 10:06 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		624,426		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	1.086727	3,781	4,109	50.00
53.00	ANESTHESIOLOGY	0.692129	1,272	880	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.288653	85,591	24,706	54.00
60.00	LABORATORY	0.298400	160,376	47,856	60.00
65.00	RESPIRATORY THERAPY	0.501343	107,284	53,786	65.00
66.00	PHYSICAL THERAPY	0.519734	301,988	156,953	66.00
67.00	OCCUPATIONAL THERAPY	0.361563	228,671	82,679	67.00
69.00	ELECTROCARDIOLOGY	0.147476	4,396	648	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.309848	266,634	82,616	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.654288	426,560	279,093	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	1.237825	0	0	90.00
91.00	EMERGENCY	0.516068	1,228	634	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.085697	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,587,781	733,960	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,587,781		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet E Part B Date/Time Prepared: 1/9/2012 10:06 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,794,052	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,794,052	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)	4,841,993	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)	33,647	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,668,337	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,140,009	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,140,009	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,140,009	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)	259,199	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	259,199	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	3,399,208	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	3,399,208	40.00
41.00	Interim payments	3,054,941	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)	344,267	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	27,647	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: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet E-1 Part I Date/Time Prepared: 1/9/2012 10:06 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,299,382		2,931,813	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	07/25/2011	99,352	03/07/2011	131,748	3.01
3.02		12/27/2010	182,049	12/27/2010	322,078	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	03/07/2011	49,457	07/25/2011	330,698	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)		231,944		123,128	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,531,326		3,054,941	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		121,466		344,267	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,652,792		3,399,208	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: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/9/2012 10:06 am

Component CCN: 14Z347 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,976,898		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	07/25/2011	172,748		0	3.01
3.02		12/27/2010	75,348		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	03/07/2011	15,138		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)		232,958		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,209,856		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		112,924		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,322,780		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: 141347 Component CCN: 14Z347	Period: From 08/01/2010 To 07/31/2011	Worksheet E-2 Date/Time Prepared: 1/9/2012 10:06 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,629,923	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)	741,300	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,665	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,371,223	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,371,223	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,371,223	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	48,443	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,322,780	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)	2,322,780	0	19.00
20.00	Interim payments	2,209,856	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)	112,924	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	13,548	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet E-3 Part V Date/Time Prepared: 1/9/2012 10:06 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	2,903,758	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)	2,903,758	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)	2,932,796	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)	2,932,796	19.00
20.00	Deductibles (exclude professional component)	337,780	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)	2,595,016	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,595,016	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	57,776	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	57,776	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))	2,652,792	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,652,792	30.00
31.00	Interim payments	2,531,326	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)	121,466	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	16,755	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet G | Date/Time Prepared: 1/9/2012 10:06 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	3,314,708	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	3,440,996	0	0	0	4.00
5.00	Other receivable	541,337	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-582,000	0	0	0	6.00
7.00	Inventory	209,967	0	0	0	7.00
8.00	Prepaid expenses	171,970	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)	7,096,978	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	602,527	0	0	0	12.00
13.00	Land improvements	1,320,018	0	0	0	13.00
14.00	Accumulated depreciation	-113,088	0	0	0	14.00
15.00	Buildings	20,446,181	0	0	0	15.00
16.00	Accumulated depreciation	-1,547,794	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,662,299	0	0	0	23.00
24.00	Accumulated depreciation	-1,400,493	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	53,591	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,023,241	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,145,186	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	1,011,920	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,157,106	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,277,325	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	520,541	0	0	0	37.00
38.00	Salaries, wages, and fees payable	522,333	0	0	0	38.00
39.00	Payroll taxes payable	95,622	0	0	0	39.00
40.00	Notes and loans payable (short term)	325,964	0	0	0	40.00
41.00	Deferred income	63,338	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	160,703	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,688,501	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,653,565	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	18,653,565	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	20,342,066	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,935,259				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)	12,935,259	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,277,325	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet G-1 | Date/Time Prepared: 1/9/2012 10:06 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		11,751,992		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-590,537				2.00
3.00	Total (sum of line 1 and line 2)		11,161,455		0		3.00
4.00	INCREASE IN PERM RESTRICTED	57,645		0			4.00
5.00	TRANSFER FROM FOUNDATION	1,716,159		0			5.00
6.00	NET ASSETS RELEASED FOR PPE	2,675,702		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		4,449,506		0		10.00
11.00	Subtotal (line 3 plus line 10)		15,610,961		0		11.00
12.00	DECREASE IN TEMP RESTRICTED	2,675,702		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)		2,675,702		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,935,259		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet G-1 | Date/Time Prepared: 1/9/2012 10:06 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	INCREASE IN PERM RESTRICTED	0		0			4.00
5.00	TRANSFER FROM FOUNDATION	0		0			5.00
6.00	NET ASSETS RELEASED FOR PPE	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	DECREASE IN TEMP RESTRICTED	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: 141347 | Period: From 08/01/2010 To 07/31/2011 | Worksheet G-2 Parts | Date/Time Prepared: 1/9/2012 10:06 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,812,354		1,812,354	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	639,151		639,151	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,451,505		2,451,505	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,451,505		2,451,505	17.00
18.00	Ancillary services	5,104,451	26,610,084	31,714,535	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,555,956	26,610,084	34,166,040	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,730,377		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		18,730,377		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141347	Period: From 08/01/2010 To 07/31/2011	Worksheet G-3 Date/Time Prepared: 1/9/2012 10:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	34,166,040	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,193,071	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,972,969	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,730,377	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-757,408	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	64,858	6.00
7.00	Income from investments	91,078	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	27,080	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	45,613	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	27,723	22.00
23.00	Governmental appropriations	0	23.00
24.00	RENT	29,172	24.00
24.01	SALES TO NON PATIENTS	6,870	24.01
24.02	PHYSICIAN SUPPORT FROM FOUNDATION	159,998	24.02
24.03	OTHER	26,455	24.03
25.00	Total other income (sum of lines 6-24)	478,847	25.00
26.00	Total (line 5 plus line 25)	-278,561	26.00
27.00	LOSS ON DISPOSAL OF EQUIPMENT	311,976	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	311,976	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-590,537	29.00