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: 141300

Period:
From 09/01/2011
To 08/31/2012

Worksheet S
Parts I-III
Date/Time Prepared:
1/30/2013 2:24 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/30/2013 Time: 2:24 pm
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. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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 certification 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 THOMAS H BOYD CRITICAL ACC HOSPITAL (141300) for the cost reporting period beginning 09/01/2011 and ending 08/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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, and that the 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	-72,493	22,668	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	37,092	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		1,653		0	10.00
10.01	RURAL HEALTH CLINIC II II	0		659		0	10.01
10.02	RURAL HEALTH CLINIC III III	0		7,259		0	10.02
10.03	RURAL HEALTH CLINIC IV IV	0		269		0	10.03
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	-35,401	32,508	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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 1/30/2013 2:24 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 SCHOOL STREET	PO Box:			1.00
2.00	City: CARROLLTON	State: IL	Zip Code: 62016	County: GREENE	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	THOMAS H BOYD CRITICAL ACC HOSPITAL	141300	99914	1	07/12/1999	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	THOMAS H BOYD CRITICAL ACC SWING BED	14Z300	99914		07/12/1999	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	GREENE COUNTY RHC	143403	99914		06/22/1995	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	T.H. BOYD RHC	143475	99914		10/02/2005	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	BOYD-FILLAGER GREENFIELD RHC	143474	99914		10/03/2005	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	RHC OF ROODHOUSE	143476	99914		10/04/2005	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									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)	09/01/2011	08/31/2012	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	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.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 1/30/2013 2:24 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
			Y/N	
			1.00	
39.00	Does this facility qualify for the Inpatient Hospital Payment Adjustment for Low Volume Hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no.			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? 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)		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 in column 1. 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, if line 63 is yes, or your facility trained residents in the base year period, 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 1/30/2013 2:24 pm

		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, if line 63 is yes, or your facility trained residents in the base year period, 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	
	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	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 1/30/2013 2:24 pm

		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 and "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.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX 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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	2.00	3.00	
	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. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 1/30/2013 2:24 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	218,396	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) 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 and applicable amendments? (see instructions) 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, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	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	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141300	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/30/2013 2:24 pm

							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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 1/30/2013 2:24 pm

		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.	N			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	12/21/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 1/30/2013 2:24 pm

		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.				Y	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

			Y/N	Date	
			1.00	2.00	
	Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JIM	JOHNSON		41.00
42.00	Enter the employer/company name of the cost report preparer.	THOMAS H. BOYD MEMORIAL HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217.942.6946	JJOHNSON@BOYDHCS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 1/30/2013 2:24 pm

		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	12/21/2012			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N				21.00
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		CFO			41.00
42.00	Enter the employer/company name of the cost report preparer.					42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.					43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part I Date/Time Prepared: 1/30/2013 2:24 pm

	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	9,150	17,844.11		1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						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	9,150	17,844.11		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	9,150	17,844.11		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	40.00	0	0			16.00
17.00	SUBPROVIDER - IRF	41.00	0	0			17.00
18.00	SUBPROVIDER	42.00	0	0			18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	45.00	0	0			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10					25.10
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.01	RURAL HEALTH CLINIC II	88.01					26.01
26.02	RURAL HEALTH CLINIC III	88.02					26.02
26.03	RURAL HEALTH CLINIC IV	88.03					26.03
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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 1/30/2013 2:24 pm

	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	668	29	755		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF Subprovider		0	0			3.00
4.00	HMO IRF Subprovider		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	581	0	581		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	680		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,249	29	2,016		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0	1,249	29	2,016		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	0	0	0		16.00
17.00	SUBPROVIDER - IRF	0	0	0	0		17.00
18.00	SUBPROVIDER	0	0	0	0		18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0		0	0		20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0		25.10
26.00	RURAL HEALTH CLINIC	0	334	0	1,683		26.00
26.01	RURAL HEALTH CLINIC II	0	645	0	5,433		26.01
26.02	RURAL HEALTH CLINIC III	0	1,292	0	3,574		26.02
26.03	RURAL HEALTH CLINIC IV	0	661	0	1,621		26.03
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	400		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 1/30/2013 2:24 pm

	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	243	1.00
2.00	HMO					0	2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						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	113.86	0.00	0	243	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0.00	0.00	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00	SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	0.00	0.00	0.00			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00	0.00	0.00			23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00	0.00	0.00			25.10
26.00	RURAL HEALTH CLINIC	0.00	1.05	0.00			26.00
26.01	RURAL HEALTH CLINIC II	0.00	2.41	0.00			26.01
26.02	RURAL HEALTH CLINIC III	0.00	1.22	0.00			26.02
26.03	RURAL HEALTH CLINIC IV	0.00	0.67	0.00			26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00	Total (sum of lines 14-26)	0.00	119.21	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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 1/30/2013 2:24 pm

	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)	18	286		1.00
2.00	HMO				2.00
3.00	HMO IPF Subprovider				3.00
4.00	HMO IRF Subprovider				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)	18	286		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF	0	0		16.00
17.00	SUBPROVIDER - IRF	0	0		17.00
18.00	SUBPROVIDER	0	0		18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
25.10	CMHC - CORF				25.10
26.00	RURAL HEALTH CLINIC				26.00
26.01	RURAL HEALTH CLINIC II				26.01
26.02	RURAL HEALTH CLINIC III				26.02
26.03	RURAL HEALTH CLINIC IV				26.03
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-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 141300 Component CCN: 143403 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-8 Date/Time Prepared: 1/30/2013 2:24 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	505 S. MAIN	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	WHITE HALL IL	62092 2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award	Date
		1.00	2.00
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

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

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0 13.00

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

		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0 15.00

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

Provider CCN: 141300
Component CCN: 143403

Period:
From 09/01/2011
To 08/31/2012

Worksheet S-8

Date/Time Prepared:
1/30/2013 2:24 pm

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		GREENE				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143403	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/30/2013 2:24 pm
		Rural Health Clinic (RHC) I	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00	08:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143403	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/30/2013 2:24 pm
		Rural Health Clinic (RHC) I	Cost

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

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

Provider CCN: 141300 Component CCN: 143475 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-8 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			800 SCHOOL STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	CARROLLTON		IL	62016	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday			
		from	to	from	to		
		1.00	2.00	3.00	4.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	18:00	09:00	18:00		11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00

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

Provider CCN: 141300
Component CCN: 143475

Period:
From 09/01/2011
To 08/31/2012

Worksheet S-8

Date/Time Prepared:
1/30/2013 2:24 pm

Rural Health Clinic (RHC) II

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		GREENE				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	18:00	09:00	18:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143475	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/30/2013 2:24 pm
		Rural Health Clinic (RHC) II	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	18:00	09:00	18:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143475	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/30/2013 2:24 pm
		Rural Health Clinic (RHC) II	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	08:00	18:00		11.00

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

Provider CCN: 141300 Component CCN: 143474 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-8 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) III | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			712 COLLEGE STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	GREENFIELD		IL	62044	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday			
		from	to	from	to		
		1.00	2.00	3.00	4.00		
	Facility hours of operations (1)						
11.00	Clinic			09:00	12:00		11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

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

Provider CCN: 141300
Component CCN: 143474

Period:
From 09/01/2011
To 08/31/2012

Worksheet S-8

Date/Time Prepared:
1/30/2013 2:24 pm

Rural Health Clinic (RHC) III

Cost

			County					
			4.00					
2.00	City, State, Zip Code, County		GREENE					2.00
		Tuesday		Wednesday				
		from	to	from	to			
		5.00	6.00	7.00	8.00			
	Facility hours of operations (1)							
11.00	Clinic	09:00	12:00	09:00	12:00			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143474	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/30/2013 2:24 pm
		Rural Health Clinic (RHC) III	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	12:00	09:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143474	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/30/2013 2:24 pm
		Rural Health Clinic (RHC) III	Cost

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

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

Provider CCN: 141300 Component CCN: 143476 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-8 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) IV | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			132 W. LORTON		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	ROODHOUSE		IL	62082	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday			
		from	to	from	to		
		1.00	2.00	3.00	4.00		
	Facility hours of operations (1)						
11.00	Clinic			08:00	12:00		11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

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

Provider CCN: 141300
Component CCN: 143476

Period:
From 09/01/2011
To 08/31/2012

Worksheet S-8

Date/Time Prepared:
1/30/2013 2:24 pm

Rural Health Clinic (RHC) IV

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		GREENE				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00	08:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143476	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/30/2013 2:24 pm
		Rural Health Clinic (RHC) IV	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00	08:00	12:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141300 Component CCN: 143476	Period: From 09/01/2011 To 08/31/2012	Worksheet S-8 Date/Time Prepared: 1/30/2013 2:24 pm
		Rural Health Clinic (RHC) IV	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet S-10 | Date/Time Prepared: 1/30/2013 2:24 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.594048	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	231,145	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	1,338,500	6.00
7.00	Medicaid cost (line 1 times line 6)	795,133	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)	563,988	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	563,988	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	191,398	43,837	235,235	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	113,700	26,041	139,741	21.00
22.00	Partial payment by patients approved for charity care	29,551	573	30,124	22.00
23.00	Cost of charity care (line 21 minus line 22)	84,149	25,468	109,617	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	799,510	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	224,391	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	575,119	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	341,648	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	451,265	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,015,253	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A | Date/Time Prepared: 1/30/2013 2:24 pm

		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	00100	NEW CAP REL COSTS-BLDG & FIXT		183,457	183,457	-119,574	63,883	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.		0	0	13,690	13,690	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	347,433	347,433	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	579,996	579,996	84,725	664,721	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	673,043	640,666	1,313,709	275,975	1,589,684	5.00
7.00	00700	OPERATION OF PLANT	49,967	128,713	178,680	1,393	180,073	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,371	13,206	33,577	0	33,577	8.00
9.00	00900	HOUSEKEEPING	71,969	30,255	102,224	7,870	110,094	9.00
10.00	01000	DIETARY	154,376	62,204	216,580	0	216,580	10.00
11.00	01101	CAFETERIA	0	0	0	0	0	11.00
13.00	01301	NURSING ADMINISTRATION	36,478	4,790	41,268	-41,268	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,255	75,241	95,496	0	95,496	14.00
15.00	01500	PHARMACY	0	239,419	239,419	0	239,419	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	86,657	15,485	102,142	0	102,142	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,167,432	173,567	1,340,999	-37,668	1,303,331	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	355,015	334,131	689,146	-151,127	538,019	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	302,966	327,157	630,123	-50,998	579,125	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	21,396	21,396	2,008	23,404	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	188,598	43,917	232,515	0	232,515	66.00
69.00	06900	ELECTROCARDIOLOGY	0	40,031	40,031	14,734	54,765	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	146,646	38,462	185,108	-19,993	165,115	88.00
88.01	08801	RURAL HEALTH CLINIC II	314,520	62,496	377,016	-37,409	339,607	88.01
88.02	08802	RURAL HEALTH CLINIC III	255,174	44,672	299,846	-51,784	248,062	88.02
88.03	08803	RURAL HEALTH CLINIC IV	188,831	48,964	237,795	-11,385	226,410	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	5,909	472	6,381	0	6,381	90.00
91.00	09100	EMERGENCY	1,334,070	143,985	1,478,055	-20,989	1,457,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	307,354	114,597	421,951	-123,237	298,714	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		0	0	-85,296	-85,296	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,679,631	3,367,279	9,046,910	-2,900	9,044,010	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	40,463	1,067	41,530	2,900	44,430	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A | Date/Time Prepared: 1/30/2013 2:24 pm

	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	
200.00	TOTAL (SUM OF LINES 118-199)	5,720,094	3,368,346	9,088,440	0	9,088,440	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	3,286	67,169		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	13,690		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-195	347,238		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-1,728	662,993		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-67,739	1,521,945		5.00
7.00	00700	OPERATION OF PLANT	-2,448	177,625		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,577		8.00
9.00	00900	HOUSEKEEPING	0	110,094		9.00
10.00	01000	DIETARY	-29,248	187,332		10.00
11.00	01101	CAFETERIA	0	0		11.00
13.00	01301	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	95,496		14.00
15.00	01500	PHARMACY	0	239,419		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,880	97,262		16.00
23.00	02300	PARAMED ED PRGM	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,303,331		30.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	538,019		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-20	579,105		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	23,404		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	-33,142	199,373		66.00
69.00	06900	ELECTROCARDIOLOGY	-40,031	14,734		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1,704	166,819		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	339,607		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	248,062		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	226,410		88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	6,381		90.00
91.00	09100	EMERGENCY	-125,171	1,331,895		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-324,892	-26,178		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
99.10	09910	CORF	0	0		99.10
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE	85,296	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-539,208	8,504,802		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	JAIL MEALS	0	0		192.01
192.02	19202	OUTPATIENT MEALS	0	0		192.02
192.03	19203	IDLE SPACE	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	44,430		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-539,208	8,549,232		200.00

RECLASSIFICATIONS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-6 | Date/Time Prepared: 1/30/2013 2:24 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	3,767		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	114,443		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	0	2,000		3.00
	TOTALS		0	120,210		
	B - RECLASS INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,622		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	83,674		2.00
	TOTALS		0	85,296		
	C - RECLASS SALARIES TO EKG COST CENTER					
1.00	ELECTROCARDIOLOGY	69.00	13,687	1,047		1.00
2.00		0.00	0	0		2.00
	TOTALS		13,687	1,047		
	D - RECLASS RHC INSURANCE ACCOUNTS					
1.00	EMPLOYEE BENEFITS	4.00	0	84,725		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	636		2.00
	TOTALS		0	85,361		
	E - NURSING ADMIN SALARY AND BENEFITS					
1.00	EMERGENCY	91.00	36,477	4,791		1.00
	TOTALS		36,477	4,791		
	F - RECLASS RHC ADMIN COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,845		1.00
2.00	OPERATION OF PLANT	7.00	0	6,913		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	23,758		
	G - RHC BUSINESS OFFICE AND HOUSEKEEPING					
1.00	ADMINISTRATIVE & GENERAL	5.00	106,672	5,665		1.00
2.00	HOUSEKEEPING	9.00	7,328	542		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		114,000	6,207		
	H - RHC LAB TIME					
1.00	LABORATORY	60.00	7,746	571		1.00
2.00	BLOOD STORING, PROCESSING & TRANS.	63.00	1,880	128		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		9,626	699		
	I - RECLASSIFY ER ADMIN TIME					
1.00	ADMINISTRATIVE & GENERAL	5.00	32,689	1,804		1.00
	TOTALS		32,689	1,804		
	J - RECLASS LEASES TO CAPITAL					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	231,368		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	231,368		
	K - RECLASS ER SALARIES AND BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	104,153	11,515		1.00
	TOTALS		104,153	11,515		
	L - ER PHYS. SAL TO RHC CARROLLTON					
1.00	RURAL HEALTH CLINIC II	88.01	13,211	3,303		1.00
	TOTALS		13,211	3,303		
	M - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	9,923		1.00
2.00	RURAL HEALTH CLINIC IV	88.03	0	1,947		2.00
3.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	2,900		3.00
	TOTALS		0	14,770		
	N - AMBULANCE COSTS IN OP OF PLANT					
1.00	AMBULANCE SERVICES	95.00	0	5,520		1.00
	TOTALS		0	5,520		
	O - CONTINUING EDUCATION COSTS IN ER					
1.00	RURAL HEALTH CLINIC	88.00	0	2,000		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	4,000		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	2,250		3.00
4.00	RURAL HEALTH CLINIC IV	88.03	0	3,000		4.00
	TOTALS		0	11,250		

RECLASSIFICATIONS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-6 | Date/Time Prepared: 1/30/2013 2:24 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	P - AMBULANCE INSURANCE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,089	1.00
	TOTALS		0	13,089	
500.00	Grand Total: Increases		323,843	619,988	500.00

RECLASSIFICATIONS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-6 | Date/Time Prepared: 1/30/2013 2:24 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	120,210	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	120,210			
	B - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	85,296	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	85,296			
	C - RECLASS SALARIES TO EKG COST CENTER						
1.00	ADULTS & PEDIATRICS	30.00	7,359	563	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	6,328	484	0		2.00
	TOTALS		13,687	1,047			
	D - RECLASS RHC INSURANCE ACCOUNTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	85,361	0		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	85,361			
	E - NURSING ADMIN SALARY AND BENEFITS						
1.00	NURSING ADMINISTRATION	13.00	36,477	4,791	0		1.00
	TOTALS		36,477	4,791			
	F - RECLASS RHC ADMIN COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	5,195	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	8,727	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	4,589	0		3.00
4.00	RURAL HEALTH CLINIC IV	88.03	0	5,247	0		4.00
	TOTALS		0	23,758			
	G - RHC BUSINESS OFFICE AND HOUSEKEEPING						
1.00	RURAL HEALTH CLINIC	88.00	13,309	872	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	47,872	1,324	0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	43,001	3,216	0		3.00
4.00	RURAL HEALTH CLINIC IV	88.03	9,818	795	0		4.00
	TOTALS		114,000	6,207			
	H - RHC LAB TIME						
1.00	RURAL HEALTH CLINIC	88.00	2,456	161	0		1.00
2.00	RURAL HEALTH CLINIC III	88.02	3,003	225	0		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	2,287	185	0		3.00
4.00	LABORATORY	60.00	1,880	128	0		4.00
	TOTALS		9,626	699			
	I - RECLASSIFY ER ADMIN TIME						
1.00	EMERGENCY	91.00	32,689	1,804	0		1.00
	TOTALS		32,689	1,804			
	J - RECLASS LEASES TO CAPITAL						
1.00	LABORATORY	60.00	0	57,307	10		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	144,315	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	29,746	0		3.00
	TOTALS		0	231,368			
	K - RECLASS ER SALARIES AND BENEFITS						
1.00	AMBULANCE SERVICES	95.00	104,153	11,515	0		1.00
	TOTALS		104,153	11,515			
	L - ER PHYS. SAL TO RHC CARROLLTON						
1.00	EMERGENCY	91.00	13,211	3,303	0		1.00
	TOTALS		13,211	3,303			
	M - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,770	13		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	13		3.00
	TOTALS		0	14,770			
	N - AMBULANCE COSTS IN OP OF PLANT						
1.00	OPERATION OF PLANT	7.00	0	5,520	0		1.00
	TOTALS		0	5,520			
	O - CONTINUING EDUCATION COSTS IN ER						
1.00	EMERGENCY	91.00	0	11,250	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
	TOTALS		0	11,250			
	P - AMBULANCE INSURANCE						
1.00	AMBULANCE SERVICES	95.00	0	13,089	0		1.00
	TOTALS		0	13,089			
500.00	Grand Total: Decreases		323,843	619,988			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/30/2013 2:24 pm

			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	70,514	0	0	0	0	1.00
2.00	Land Improvements	36,143	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,343,935	6,310	0	6,310	0	3.00
4.00	Building Improvements	1,109,924	0	0	0	0	4.00
5.00	Fixed Equipment	84,028	0	0	0	0	5.00
6.00	Movable Equipment	1,722,996	338,284	0	338,284	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,367,540	344,594	0	344,594	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	4,367,540	344,594	0	344,594	0	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	150,432	0	0	33,025	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	150,432	0	0	33,025	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	2,580,340	0	2,580,340	0.574642	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,910,002	0	1,910,002	0.425358	0	2.00
3.00	Total (sum of lines 1-2)	4,490,342	0	4,490,342	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/30/2013 2:24 pm

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	70,514	0	1.00
2.00	Land Improvements	36,143	0	2.00
3.00	Buildings and Fixtures	1,350,245	0	3.00
4.00	Building Improvements	1,109,924	0	4.00
5.00	Fixed Equipment	84,028	0	5.00
6.00	Movable Equipment	2,061,280	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,712,134	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	4,712,134	0	10.00

		SUMMARY OF CAPITAL		
	Cost Center Description	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	183,457	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	183,457	3.00

		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Cost Center Description	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	33,508	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	3,767	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	114,443	231,368	2.00
3.00	Total (sum of lines 1-2)	0	0	0	151,718	231,368	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/30/2013 2:24 pm

	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	33,661	0	0	67,169	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	9,923	0	13,690	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,427	0	0	0	347,238	2.00
3.00	Total (sum of lines 1-2)	1,427	33,661	9,923	0	428,097	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8 | Date/Time Prepared: 1/30/2013 2:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT NON HOSP. (chapter 2)		0	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-195	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-5,940	ADMINISTRATIVE & GENERAL	5.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)	A	-1,613	ADMINISTRATIVE & GENERAL	5.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-153,078			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	-29,248	DIETARY	10.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-4,880	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	*** Cost Center Deleted ***	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	UTILIZATION REVIEW-SNF	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT NON HOSP.		0	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	INTEREST EXPENSE	A	85,296	INTEREST EXPENSE	113.00	33.00
33.01	HEALTHLINK FEES - HOSPITAL	A	17,167	ADMINISTRATIVE & GENERAL	5.00	33.01
34.00	HEALTHLINK FEES - RHC WHITE HALL	A	1,704	RURAL HEALTH CLINIC	88.00	34.00
36.00	INTREST PAID TO MEDICARE	A	-34,199	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	RENTAL INCOME	B	-9,050	ADMINISTRATIVE & GENERAL	5.00	37.00
38.00	ER PHYSICIAN BENEFIT COSTS	A	-12,124	EMERGENCY	91.00	38.00
39.00			0		0.00	39.00
40.01			0		0.00	40.01
42.00	DEPRECIATION ADJUSTMENT	A	3,286	NEW CAP REL COSTS-BLDG & FIXT	1.00	42.00
44.00	MISC. INC.	B	-1,728	EMPLOYEE BENEFITS	4.00	44.00
44.01	MISC. INC.	B	-2,109	ADMINISTRATIVE & GENERAL	5.00	44.01
44.02	MISC. INC.	B	-2,448	OPERATION OF PLANT	7.00	44.02
44.03	MISC. INC.	B	-20	LABORATORY	60.00	44.03
44.04	MISC. INC	B	-580	AMBULANCE SERVICES	95.00	44.04
44.05	HEALTH FAIR	B	-14,913	ADMINISTRATIVE & GENERAL	5.00	44.05

ADJUSTMENTS TO EXPENSES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8 | Date/Time Prepared: 1/30/2013 2:24 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
44.06			0		0.00	44.06
45.00	AMBULANCE SUBSIDY - OPERATIONS	B	-324,312	AMBULANCE SERVICES	95.00	45.00
45.01	AMBULANCE SUBSIBY - MANAGEMENT	B	-17,082	ADMINISTRATIVE & GENERAL	5.00	45.01
46.00	GREENE COUNTY HEALTH PT COST	A	-33,142	PHYSICAL THERAPY	66.00	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-539,208			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8 | Date/Time Prepared: 1/30/2013 2:24 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT NON HOSP. (chapter 2)	0		1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	11		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0		26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT NON HOSP.	0		26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	INTEREST EXPENSE	0		33.00
33.01	HEALTHLINK FEES - HOSPITAL	0		33.01
34.00	HEALTHLINK FEES - RHC WHITE HALL	0		34.00
36.00	INTREST PAID TO MEDICARE	0		36.00
37.00	RENTAL INCOME	9		37.00
38.00	ER PHYSICIAN BENEFIT COSTS	0		38.00
39.00		0		39.00
40.01		0		40.01
42.00	DEPRECIATION ADJUSTMENT	9		42.00
44.00	MISC. INC.	0		44.00
44.01	MISC. INC.	0		44.01
44.02	MISC. INC.	0		44.02
44.03	MISC. INC.	0		44.03
44.04	MISC. INC	0		44.04
44.05	HEALTH FAIR	0		44.05
44.06		0		44.06
45.00	AMBULANCE SUBSIDY - OPERATIONS	0		45.00
45.01	AMBULANCE SUBSIBY - MANAGEMENT	0		45.01
46.00	GREENE COUNTY HEALTH PT COST	0		46.00
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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 1/30/2013 2:24 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	756,594	113,047	1.00
2.00		60.00	LABORATORY	4,500	0	2.00
3.00		69.00	ELECTROCARDIOLOGY	40,031	40,031	3.00
4.00		88.00	RURAL HEALTH CLINIC	7,500	0	4.00
5.00		88.00	RURAL HEALTH CLINIC	5,500	0	5.00
6.00		88.03	RURAL HEALTH CLINIC IV	15,250	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				829,375	153,078	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 1/30/2013 2:24 pm

		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		643,547	0	0	0	0	1.00
2.00		4,500	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		7,500	0	0	0	0	4.00
5.00		5,500	0	0	0	0	5.00
6.00		15,250	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		676,297		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 1/30/2013 2:24 pm

		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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 1/30/2013 2:24 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	113,047		1.00
2.00		0	0		2.00
3.00		0	40,031		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	153,078		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 1/30/2013 2:24 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		117	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	236.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	34.75	34.75	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	17.38	17.38	0.00			11.00
12.00	Number of travel hours (provider site)	0	67	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	8,227	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	8,227	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	8,227	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	34.75	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	27,105	22.00
23.00	Total salary equivalency (see instructions)	27,105	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	2,033	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	2,033	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	2,033	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	2,328	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	2,328	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	2,033	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	2,328	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	2,328	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 1/30/2013 2:24 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	34.75	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	27,105	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	2,033	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	29,138	63.00
64.00	Total cost of outside supplier services (from your records)	17,531	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	2,033	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	2,033	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	2,328	101.01
101.02	Line 34 = sum of lines 27 and 31	2,328	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	2,328	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	2,328	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
				NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	67,169	67,169				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	13,690	0	13,690			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	347,238			347,238		2.00
4.00	00400	EMPLOYEE BENEFITS	662,993	0	0	0	662,993	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,521,945	8,231	1,672	13,892	106,234	5.00
7.00	00700	OPERATION OF PLANT	177,625	2,462	0	1,305	5,791	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,577	2,365	0	340	2,361	8.00
9.00	00900	HOUSEKEEPING	110,094	494	0	0	9,191	9.00
10.00	01000	DIETARY	187,332	6,975	0	0	17,893	10.00
11.00	01101	CAFETERIA	0	0	0	0	0	11.00
13.00	01301	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95,496	1,325	0	0	2,348	14.00
15.00	01500	PHARMACY	239,419	909	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,262	1,734	0	284	10,044	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,303,331	21,012	0	31,823	134,459	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	538,019	4,115	0	214,324	40,415	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	579,105	2,179	0	57,955	35,795	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,404	0	0	0	218	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	199,373	3,475	0	1,648	21,860	66.00
69.00	06900	ELECTROCARDIOLOGY	14,734	0	0	0	1,586	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	166,819	0	0	7,172	15,170	88.00
88.01	08801	RURAL HEALTH CLINIC II	339,607	3,542	0	7,332	32,437	88.01
88.02	08802	RURAL HEALTH CLINIC III	248,062	0	0	0	24,244	88.02
88.03	08803	RURAL HEALTH CLINIC IV	226,410	0	0	7,172	20,484	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	6,381	358	0	0	685	90.00
91.00	09100	EMERGENCY	1,331,895	6,561	0	3,991	153,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	-26,178	1,009	0	0	23,552	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,504,802	66,746	1,672	347,238	658,303	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
				NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	44,430	423	12,018	0	4,690	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,549,232	67,169	13,690	347,238	662,993	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,651,974	1,651,974				5.00
7.00	00700	OPERATION OF PLANT	187,183	44,822	232,005			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,643	9,253	9,800	57,696		8.00
9.00	00900	HOUSEKEEPING	119,779	28,682	2,045	3,011	153,517	9.00
10.00	01000	DIETARY	212,200	50,813	26,861	145	3,300	10.00
11.00	01101	CAFETERIA	0	0	0	0	0	11.00
13.00	01301	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	99,169	23,747	5,492	0	0	14.00
15.00	01500	PHARMACY	240,328	57,548	3,769	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,324	26,178	7,185	0	480	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,490,625	356,939	87,085	38,004	100,964	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	796,873	190,816	17,053	2,809	4,396	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	675,034	161,641	9,028	0	4,306	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,622	5,656	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	226,356	54,202	14,401	3,032	354	66.00
69.00	06900	ELECTROCARDIOLOGY	16,320	3,908	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	189,161	45,296	0	64	5,711	88.00
88.01	08801	RURAL HEALTH CLINIC II	382,918	91,692	14,678	0	9,346	88.01
88.02	08802	RURAL HEALTH CLINIC III	272,306	65,205	0	113	8,702	88.02
88.03	08803	RURAL HEALTH CLINIC IV	254,066	60,838	0	6	5,711	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,424	1,778	1,484	0	0	90.00
91.00	09100	EMERGENCY	1,495,983	358,219	27,190	7,465	8,521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	-1,617	0	4,181	3,047	462	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,487,671	1,637,233	230,252	57,696	152,253	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	61,561	14,741	1,753	0	1,264	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,549,232	1,651,974	232,005	57,696	153,517	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	293,319					10.00
11.00	01101	CAFETERIA	158,313	158,313				11.00
13.00	01301	NURSING ADMINISTRATION	0	0	0			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,876	0	130,284		14.00
15.00	01500	PHARMACY	0	0	0	0	301,645	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,357	0	0	0	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	135,006	50,565	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,783	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	13,427	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	7,670	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	130,284	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	301,645	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	12,268	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	221	0	0	0	90.00
91.00	09100	EMERGENCY	0	33,035	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,253	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	293,319	156,455	0	130,284	301,645	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	1,858	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I Date/Time Prepared: 1/30/2013 2:24 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
202.00	TOTAL (sum lines 118-201)	293,319	158,313	0	130,284	301,645	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01101	CAFETERIA						11.00
13.00	01301	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	150,524					16.00
23.00	02300	PARAMED ED PRGM	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,310	0	2,311,498	0	2,311,498	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,182	0	1,048,912	0	1,048,912	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	35,774	0	899,210	0	899,210	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	29,278	0	29,278	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	6,335	0	312,350	0	312,350	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	20,228	0	20,228	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	130,284	0	130,284	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	301,645	0	301,645	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	240,232	0	240,232	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,433	0	513,335	0	513,335	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	346,326	0	346,326	88.02
88.03	08803	RURAL HEALTH CLINIC IV	36	0	320,657	0	320,657	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	3,874	0	14,781	0	14,781	90.00
91.00	09100	EMERGENCY	25,196	0	1,955,609	0	1,955,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	384	0	23,710	0	23,710	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	150,524	0	8,468,055	0	8,468,055	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	81,177	0	81,177	194.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part I Date/Time Prepared: 1/30/2013 2:24 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	23.00	24.00	25.00	26.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	150,524	0	8,549,232	0	8,549,232	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	8,231	1,672	13,892	23,795	5.00
7.00	00700	OPERATION OF PLANT	0	2,462	0	1,305	3,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,365	0	340	2,705	8.00
9.00	00900	HOUSEKEEPING	0	494	0	0	494	9.00
10.00	01000	DIETARY	0	6,975	0	0	6,975	10.00
11.00	01101	CAFETERIA	0	0	0	0	0	11.00
13.00	01301	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,325	0	0	1,325	14.00
15.00	01500	PHARMACY	0	909	0	0	909	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,734	0	284	2,018	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	21,012	0	31,823	52,835	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,115	0	214,324	218,439	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,179	0	57,955	60,134	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	3,475	0	1,648	5,123	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,172	7,172	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,542	0	7,332	10,874	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	7,172	7,172	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	358	0	0	358	90.00
91.00	09100	EMERGENCY	0	6,561	0	3,991	10,552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,009	0	0	1,009	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	66,746	1,672	347,238	415,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
				NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
			0	1.00	1.01	2.00	2A	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	423	12,018	0	12,441	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	67,169	13,690	347,238	428,097	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	23,795				5.00
7.00	00700	OPERATION OF PLANT	0	646	4,413			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	133	186	3,024		8.00
9.00	00900	HOUSEKEEPING	0	413	39	158	1,104	9.00
10.00	01000	DIETARY	0	732	511	8	24	10.00
11.00	01101	CAFETERIA	0	0	0	0	0	11.00
13.00	01301	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	342	104	0	0	14.00
15.00	01500	PHARMACY	0	829	72	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	377	137	0	3	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	5,141	1,657	1,992	726	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,748	324	147	32	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,328	172	0	31	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	81	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	781	274	159	3	66.00
69.00	06900	ELECTROCARDIOLOGY	0	56	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	652	0	3	41	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,321	279	0	67	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	939	0	6	63	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	876	0	0	41	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	26	28	0	0	90.00
91.00	09100	EMERGENCY	0	5,162	517	391	61	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	80	160	3	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	23,583	4,380	3,024	1,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	212	33	0	9	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	23,795	4,413	3,024	1,104	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	8,250					10.00
11.00	01101	CAFETERIA	4,453	4,453				11.00
13.00	01301	NURSING ADMINISTRATION	0	0	0			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	53	0	1,824		14.00
15.00	01500	PHARMACY	0	0	0	0	1,810	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	207	0	0	0	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,797	1,422	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	360	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	378	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	216	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,824	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,810	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	345	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	6	0	0	0	90.00
91.00	09100	EMERGENCY	0	929	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	485	0	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,250	4,401	0	1,824	1,810	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	52	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II Date/Time Prepared: 1/30/2013 2:24 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
202.00	TOTAL (sum lines 118-201)	8,250	4,453	0	1,824	1,810	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01101	CAFETERIA						11.00
13.00	01301	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,742					16.00
23.00	02300	PARAMED ED PRGM	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	952		68,522	0	68,522	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	441		222,491	0	222,491	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	652		63,695	0	63,695	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		81	0	81	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	115		6,671	0	6,671	66.00
69.00	06900	ELECTROCARDIOLOGY	0		56	0	56	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1,824	0	1,824	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		1,810	0	1,810	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		7,868	0	7,868	88.00
88.01	08801	RURAL HEALTH CLINIC II	44		12,930	0	12,930	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		1,008	0	1,008	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1		8,090	0	8,090	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	71		489	0	489	90.00
91.00	09100	EMERGENCY	459		18,071	0	18,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7		1,744	0	1,744	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.10	09910	CORF	0		0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0		0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,742	0	415,350	0	415,350	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	190.00
191.00	19100	RESEARCH	0		0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
192.01	19201	JAIL MEALS	0		0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0		0	0	0	192.02
192.03	19203	IDLE SPACE	0		0	0	0	192.03
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0		12,747	0	12,747	194.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B Part II Date/Time Prepared: 1/30/2013 2:24 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	23.00	24.00	25.00	26.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,742	0	428,097	0	428,097	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NON HOSP. (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	37,153					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	7,074				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			345,812			2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	5,720,094		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,553	864	13,835	916,557	-1,651,974	5.00
7.00	00700	OPERATION OF PLANT	1,362	0	1,300	49,967	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,308	0	339	20,371	0	8.00
9.00	00900	HOUSEKEEPING	273	0	0	79,297	0	9.00
10.00	01000	DIETARY	3,858	0	0	154,376	0	10.00
11.00	01101	CAFETERIA	0	0	0	0	0	11.00
13.00	01301	NURSING ADMINISTRATION	0	0	0	1	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	733	0	0	20,255	0	14.00
15.00	01500	PHARMACY	503	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	959	0	283	86,657	0	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,623	0	31,692	1,160,073	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,276	0	213,442	348,687	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,205	0	57,717	308,832	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,880	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,922	0	1,641	188,598	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,687	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	7,143	130,881	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,959	0	7,302	279,859	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	209,170	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	7,143	176,726	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	198	0	0	5,909	0	90.00
91.00	09100	EMERGENCY	3,629	0	3,975	1,324,647	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	558	0	0	203,201	1,617	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,919	864	345,812	5,679,631	-1,650,357	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NON HOSP. (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	234	6,210	0	40,463	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	67,169	13,690	347,238	662,993		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.807902	1.935256	1.004124	0.115906		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,898,875					5.00
7.00	00700	OPERATION OF PLANT	187,183	30,965				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,643	1,308	56,193			8.00
9.00	00900	HOUSEKEEPING	119,779	273	2,933	84,677		9.00
10.00	01000	DIETARY	212,200	3,585	141	1,820	15,530	10.00
11.00	01101	CAFETERIA	0	0	0	0	8,382	11.00
13.00	01301	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	99,169	733	0	0	0	14.00
15.00	01500	PHARMACY	240,328	503	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,324	959	0	265	0	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,490,625	11,623	37,013	55,690	7,148	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	796,873	2,276	2,736	2,425	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	675,034	1,205	0	2,375	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,622	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	226,356	1,922	2,953	195	0	66.00
69.00	06900	ELECTROCARDIOLOGY	16,320	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	189,161	0	62	3,150	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	382,918	1,959	0	5,155	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	272,306	0	110	4,800	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	254,066	0	6	3,150	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,424	198	0	0	0	90.00
91.00	09100	EMERGENCY	1,495,983	3,629	7,271	4,700	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	558	2,968	255	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,837,314	30,731	56,193	83,980	15,530	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	61,561	234	0	697	0	194.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/30/2013 2:24 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,651,974	232,005	57,696	153,517	293,319	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.239456	7.492492	1.026747	1.812972	18.887250	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	23,795	4,413	3,024	1,104	8,250	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.003449	0.142516	0.053815	0.013038	0.531230	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01101	CAFETERIA	8,607					11.00
13.00	01301	NURSING ADMINISTRATION	0	100				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	102	0	100			14.00
15.00	01500	PHARMACY	0	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	400	0	0	0	103,950	16.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,749	100	0	0	36,125	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	695	0	0	0	16,700	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	730	0	0	0	24,705	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	417	0	0	0	4,375	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	667	0	0	0	1,680	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	25	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	12	0	0	0	2,675	90.00
91.00	09100	EMERGENCY	1,796	0	0	0	17,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	938	0	0	0	265	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.10	09910	CORF	0	0	0	0	0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,506	100	100	100	103,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	JAIL MEALS	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT MEALS	0	0	0	0	0	192.02
192.03	19203	IDLE SPACE	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	101	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	158,313	0	130,284	301,645	150,524	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.393517	0.000000	1,302.840000	3,016.450000	1.448042	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,453	0	1,824	1,810	2,742	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.517370	0.000000	18.240000	18.100000	0.026378	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
			23.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01101	CAFETERIA			11.00
13.00	01301	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
23.00	02300	PARAMED ED PRGM	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
40.00	04000	SUBPROVIDER - IPF	0		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVIDER	0		42.00
45.00	04500	NURSING FACILITY	0		45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0		59.00
60.00	06000	LABORATORY	0		60.00
60.01	06001	BLOOD LABORATORY	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
66.00	06600	PHYSICAL THERAPY	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0		88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		89.00
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0		98.00
99.10	09910	CORF	0		99.10
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0		110.00
111.00	11100	ISLET ACQUISITION	0		111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
192.01	19201	JAIL MEALS	0		192.01
192.02	19202	OUTPATIENT MEALS	0		192.02
192.03	19203	IDLE SPACE	0		192.03
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0		194.00
200.00		Cross Foot Adjustments			200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet B-1 | Date/Time Prepared: 1/30/2013 2:24 pm

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
			23.00		
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/30/2013 2:24 pm

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	03000	ADULTS & PEDIATRICS	2,311,498		2,311,498	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,048,912		1,048,912	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	899,210		899,210	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	29,278		29,278	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	312,350	0	312,350	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	20,228		20,228	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,284		130,284	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,645		301,645	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	240,232		240,232	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	513,335		513,335	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	346,326		346,326	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	320,657		320,657	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	14,781		14,781	0	0	90.00
91.00	09100	EMERGENCY	1,955,609		1,955,609	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	513,180		513,180		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	23,710		23,710	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0		0		0	117.00
200.00		Subtotal (see instructions)	8,981,235	0	8,981,235	0	0	200.00
201.00		Less Observation Beds	513,180		513,180		0	201.00
202.00		Total (see instructions)	8,468,055	0	8,468,055	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/30/2013 2:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,094,304		1,094,304			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	155,901	3,061,952	3,217,853	0.325966	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	260,802	2,571,025	2,831,827	0.317537	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	41,316	109,716	151,032	0.193853	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	66,085	718,100	784,185	0.398312	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	17,676	339,810	357,486	0.056584	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	339,745	366,768	706,513	0.184404	0.000000	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	439,448	376,865	816,313	0.369521	0.000000	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	256,840	256,840			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	310,373	310,373			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	242,366	242,366			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	163,804	163,804			88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	23,277	23,277	0.635005	0.000000	90.00
91.00	09100	EMERGENCY	2,299	1,464,767	1,467,066	1.333007	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	815,346	815,346	0.629402	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,016,239	1,016,239	0.023331	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0			117.00
200.00		Subtotal (see instructions)	2,417,576	11,837,248	14,254,824			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,417,576	11,837,248	14,254,824			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/30/2013 2:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08802	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.10	09910	CORF			99.10
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)			117.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/30/2013 2:24 pm

Title XIX | 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	03000	ADULTS & PEDIATRICS	2,311,498		2,311,498	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,048,912		1,048,912	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	899,210		899,210	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	29,278		29,278	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	312,350	0	312,350	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	20,228		20,228	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,284		130,284	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,645		301,645	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	240,232		240,232	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	513,335		513,335	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	346,326		346,326	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	320,657		320,657	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	14,781		14,781	0	0	90.00
91.00	09100	EMERGENCY	1,955,609		1,955,609	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	513,180		513,180		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	23,710		23,710	0	0	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
99.10	09910	CORF	0		0		0	99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0		0		0	117.00
200.00		Subtotal (see instructions)	8,981,235	0	8,981,235	0	0	200.00
201.00		Less Observation Beds	513,180		513,180		0	201.00
202.00		Total (see instructions)	8,468,055	0	8,468,055	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/30/2013 2:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,094,304		1,094,304			30.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	155,901	3,061,952	3,217,853	0.325966	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	260,802	2,571,025	2,831,827	0.317537	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	41,316	109,716	151,032	0.193853	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	66,085	718,100	784,185	0.398312	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	17,676	339,810	357,486	0.056584	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	339,745	366,768	706,513	0.184404	0.000000	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	439,448	376,865	816,313	0.369521	0.000000	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	256,840	256,840	0.935337	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	310,373	310,373	1.653929	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	242,366	242,366	1.428938	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	163,804	163,804	1.957565	0.000000	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	23,277	23,277	0.635005	0.000000	90.00
91.00	09100	EMERGENCY	2,299	1,464,767	1,467,066	1.333007	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	815,346	815,346	0.629402	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,016,239	1,016,239	0.023331	0.000000	95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
99.10	09910	CORF	0	0	0			99.10
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)	0	0	0			117.00
200.00		Subtotal (see instructions)	2,417,576	11,837,248	14,254,824			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,417,576	11,837,248	14,254,824			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet C Part I Date/Time Prepared: 1/30/2013 2:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.10	09910	CORF			99.10
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
117.00	06950	OTHER SPECIAL PURPOSE (SPECIFY)			117.00
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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part II Date/Time Prepared: 1/30/2013 2:24 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,491	3,217,853	0.069143	102,302	7,073	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	63,695	2,831,827	0.022493	191,410	4,305	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	81	151,032	0.000536	15,876	9	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	6,671	784,185	0.008507	5,265	45	66.00
69.00	06900	ELECTROCARDIOLOGY	56	357,486	0.000157	6,067	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,824	706,513	0.002582	181,348	468	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,810	816,313	0.002217	242,523	538	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,868	256,840	0.030634	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,930	310,373	0.041660	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,008	242,366	0.004159	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	8,090	163,804	0.049388	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	489	23,277	0.021008	0	0	90.00
91.00	09100	EMERGENCY	18,071	1,467,066	0.012318	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	815,346	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	345,084	12,144,281		744,791	12,439	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part IV Date/Time Prepared: 1/30/2013 2:24 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part IV Date/Time Prepared: 1/30/2013 2:24 pm

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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,217,853	0.000000	0.000000	102,302	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	2,831,827	0.000000	0.000000	191,410	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	151,032	0.000000	0.000000	15,876	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
66.00	06600	PHYSICAL THERAPY	0	784,185	0.000000	0.000000	5,265	66.00
69.00	06900	ELECTROCARDIOLOGY	0	357,486	0.000000	0.000000	6,067	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	706,513	0.000000	0.000000	181,348	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	816,313	0.000000	0.000000	242,523	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	256,840	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	310,373	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	242,366	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	163,804	0.000000	0.000000	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	23,277	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,467,066	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	815,346	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	12,144,281			744,791	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part IV Date/Time Prepared: 1/30/2013 2:24 pm

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					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part V Date/Time Prepared: 1/30/2013 2:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325966	0	1,350,404	0		54.00
57.00	05700	CT SCAN	0.000000	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	06000	LABORATORY	0.317537	0	1,364,164	0		60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.193853	0	41,172	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0.398312	0	260,757	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0.056584	0	117,738	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.184404	0	169,281	0		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.369521	0	164,498	1,213		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000					88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000					88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000					88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000	CLINIC	0.635005	0	17,991	0		90.00
91.00	09100	EMERGENCY	1.333007	0	733,983	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.629402	0	316,842	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.023331		0			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0		98.00
200.00		Subtotal (see instructions)		0	4,536,830	1,213		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	4,536,830	1,213		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part V Date/Time Prepared: 1/30/2013 2:24 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs PPS Services (see inst.)	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	440,186	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	433,173	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	7,981	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	103,863	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,662	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,216	0		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60,785	448		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	11,424	0		90.00
91.00	09100	EMERGENCY	0	978,404	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	199,421	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Subtotal (see instructions)	0	2,273,115	448		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	2,273,115	448		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part V | Date/Time Prepared: 1/30/2013 2:24 pm

Component CCN: 14Z300 | 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 inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325966	0	0	0		54.00
57.00	05700	CT SCAN	0.000000	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	06000	LABORATORY	0.317537	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.193853	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0.398312	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0.056584	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.184404	0	0	0		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.369521	0	0	0		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000					88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000					88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000					88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000	CLINIC	0.635005	0	0	0		90.00
91.00	09100	EMERGENCY	1.333007	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.629402	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.023331		0			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0		98.00
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: 141300 | Component CCN: 14Z300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D Part V Date/Time Prepared: 1/30/2013 2:24 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: PPS Services (see inst.)	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-1 | Date/Time Prepared: 1/30/2013 2:24 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,416	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,155	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	755	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	205	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)	376	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	269	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)	411	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	668	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)	205	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)	376	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	122.80	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	124.72	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,311,498	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	33,033	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)	51,260	25.00
26.00	Total swing-bed cost (see instructions)	829,687	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,481,811	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	733,568	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	733,568	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.020005	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)	971.61	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,481,811	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,282.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	857,011	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)	857,011	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-1 | Date/Time Prepared: 1/30/2013 2:24 pm

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)	222,703	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,079,714	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	263,005	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	482,389	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	745,394	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)	400	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,282.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	513,180	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-1 | Date/Time Prepared: 1/30/2013 2:24 pm

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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-3 | Date/Time Prepared: 1/30/2013 2:24 pm

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	03000	ADULTS & PEDIATRICS		685,858		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325966	102,302	33,347	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.317537	191,410	60,780	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.193853	15,876	3,078	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.398312	5,265	2,097	66.00
69.00	06900	ELECTROCARDIOLOGY	0.056584	6,067	343	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.184404	181,348	33,441	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.369521	242,523	89,617	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.635005	0	0	90.00
91.00	09100	EMERGENCY	1.333007	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.629402	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		744,791	222,703	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)		744,791		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141300 | Component CCN: 14Z300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet D-3 | Date/Time Prepared: 1/30/2013 2:24 pm

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	03000	ADULTS & PEDIATRICS		0		30.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.325966	41,567	13,549	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.317537	64,620	20,519	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.193853	1,626	315	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.398312	59,906	23,861	66.00
69.00	06900	ELECTROCARDIOLOGY	0.056584	1,637	93	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.184404	98,415	18,148	71.00
71.30	07101	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	71.30
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.369521	145,073	53,608	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.635005	0	0	90.00
91.00	09100	EMERGENCY	1.333007	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.629402	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		412,844	130,093	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)		412,844		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141300	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part B Date/Time Prepared: 1/30/2013 2:24 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,273,563	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,273,563	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,296,299	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)	21,552	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	628,875	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,645,872	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,645,872	30.00
31.00	Primary payer payments	1,013	31.00
32.00	Subtotal (line 30 minus line 31)	1,644,859	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)	187,266	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	187,266	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	160,872	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,832,125	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	1,832,125	40.00
41.00	Interim payments	1,809,457	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)	22,668	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 1/30/2013 2:24 pm

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		868,318		1,572,014	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/24/2012	25,178	02/24/2012	67,568	3.01
3.02		12/16/2011	423	12/16/2011	56,954	3.02
3.03		08/27/2012	112,921	08/27/2012	112,921	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		138,522		237,443	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,006,840		1,809,457	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		22,668	6.01
6.02	SETTLEMENT TO PROGRAM		72,493		0	6.02
7.00	Total Medicare program liability (see instructions)		934,347		1,832,125	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: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 1/30/2013 2:24 pm

Component CCN: 14Z300 | 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		705,082		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/24/2012	22,083		0	3.01
3.02		08/27/2012	111,218		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	12/16/2011	1,017		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)		132,284		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)		837,366		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		37,092		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		874,458		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: 141300 | Component CCN: 14Z300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet E-2 | Date/Time Prepared: 1/30/2013 2:24 pm

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)	752,848	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)	131,394	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	581	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)	884,242	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	884,242	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)	884,242	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,784	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)	874,458	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)	874,458	0	19.00
20.00	Interim payments	837,366	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)	37,092	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141300	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part V Date/Time Prepared: 1/30/2013 2:24 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	1,079,714	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,079,714	4.00
5.00	Primary payer payments	1,388	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,089,123	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)	1,089,123	19.00
20.00	Deductibles (exclude professional component)	188,120	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	901,003	22.00
23.00	Coinsurance	1,734	23.00
24.00	Subtotal (line 22 minus line 23)	899,269	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,078	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	35,078	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,691	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	934,347	28.00
29.00	NET MSP PAYMENTS	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	934,347	30.00
31.00	Interim payments	1,006,840	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)	-72,493	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G | Date/Time Prepared: 1/30/2013 2:24 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	81,866	0	0	0	1.00
2.00	Temporary investments	32,991	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,518,005	0	0	0	4.00
5.00	Other receivable	374,998	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,237,049	0	0	0	6.00
7.00	Inventory	22,157	0	0	0	7.00
8.00	Prepaid expenses	32,931	0	0	0	8.00
9.00	Other current assets	79,981	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)	1,905,880	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	70,513	0	0	0	12.00
13.00	Land improvements	36,143	0	0	0	13.00
14.00	Accumulated depreciation	-36,143	0	0	0	14.00
15.00	Buildings	2,453,859	0	0	0	15.00
16.00	Accumulated depreciation	-2,249,269	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	84,028	0	0	0	19.00
20.00	Accumulated depreciation	-81,398	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	2,131,224	0	0	0	23.00
24.00	Accumulated depreciation	-1,598,582	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	810,375	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	2,716,255	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,672,927	0	0	0	37.00
38.00	Salaries, wages, and fees payable	437,374	0	0	0	38.00
39.00	Payroll taxes payable	241,916	0	0	0	39.00
40.00	Notes and loans payable (short term)	248,563	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	132,911	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,733,691	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	895,180	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	895,180	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,628,871	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-912,616				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)	-912,616	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	2,716,255	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G-1 | Date/Time Prepared: 1/30/2013 2:24 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		-1,512,882		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		600,266				2.00
3.00	Total (sum of line 1 and line 2)		-912,616		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-912,616		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-912,616		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G-1 | Date/Time Prepared: 1/30/2013 2:24 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/30/2013 2:24 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	733,568		733,568	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	317,609		317,609	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,051,177		1,051,177	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,051,177		1,051,177	17.00
18.00	Ancillary services	1,521,006	5,315,057	6,836,063	18.00
19.00	Outpatient services	0	5,315,057	5,315,057	19.00
20.00	RURAL HEALTH CLINIC	0	256,840	256,840	20.00
20.01	RURAL HEALTH CLINIC II	0	310,373	310,373	20.01
20.02	RURAL HEALTH CLINIC III	0	242,366	242,366	20.02
20.03	RURAL HEALTH CLINIC IV	0	163,804	163,804	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,016,239	1,016,239	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,572,183	12,619,736	15,191,919	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		9,088,440		29.00
30.00	BAD DEBTS	799,510			30.00
31.00	INTEREST EXPENSE	85,296			31.00
32.00	HEALTHLINK FEES - RHC WHITE HALL	1,704			32.00
33.00	HEALTHLINK FEES - HOSPITAL	17,167			33.00
34.00		0			34.00
35.00		274			35.00
36.00	Total additions (sum of lines 30-35)		903,951		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)		9,992,391		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet G-3 | Date/Time Prepared: 1/30/2013 2:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	15,191,919	1.00
2.00	Less contractual allowances and discounts on patients' accounts	5,374,769	2.00
3.00	Net patient revenues (line 1 minus line 2)	9,817,150	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	9,992,391	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-175,241	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	185,193	6.00
7.00	Income from investments	10,241	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	29,248	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	4,880	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	WELL CTR/AMB/NON-REIMB/GAIN LOSS	545,945	24.00
25.00	Total other income (sum of lines 6-24)	775,507	25.00
26.00	Total (line 5 plus line 25)	600,266	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	600,266	29.00

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

Provider CCN: 141300 Component CCN: 143403 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	4,752	311	5,063	0	5,063	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	87,296	5,717	93,013	2,000	95,013	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	41,289	2,703	43,992	0	43,992	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	13,309	872	14,181	-14,181	0	9.00
10.00	Subtotal (sum of lines 1-9)	146,646	9,603	156,249	-12,181	144,068	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	11,000	11,000	0	11,000	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	11,000	11,000	0	11,000	14.00
15.00	Medical Supplies	0	2,851	2,851	0	2,851	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	15,008	15,008	-7,812	7,196	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	17,859	17,859	-7,812	10,047	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	146,646	38,462	185,108	-19,993	165,115	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	146,646	38,462	185,108	-19,993	165,115	32.00

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

Provider CCN: 141300 | Component CCN: 143403 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	5,063		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	95,013		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	43,992		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	144,068		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	11,000		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	11,000		14.00
15.00	Medical Supplies	0	2,851		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	1,704	8,900		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	1,704	11,751		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,704	166,819		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,704	166,819		32.00

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

Provider CCN: 141300 Component CCN: 143475 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	5,899	163	6,062	16,514	22,576	1.00
2.00	Physician Assistant	81,029	2,241	83,270	2,000	85,270	2.00
3.00	Nurse Practitioner	99,051	2,740	101,791	2,000	103,791	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	71,930	1,990	73,920	0	73,920	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	56,611	1,566	58,177	-49,196	8,981	9.00
10.00	Subtotal (sum of lines 1-9)	314,520	8,700	323,220	-28,682	294,538	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	29,323	29,323	0	29,323	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	29,323	29,323	0	29,323	14.00
15.00	Medical Supplies	0	10,275	10,275	0	10,275	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	14,198	14,198	-8,727	5,471	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	24,473	24,473	-8,727	15,746	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	314,520	62,496	377,016	-37,409	339,607	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	314,520	62,496	377,016	-37,409	339,607	32.00

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

Provider CCN: 141300 | Component CCN: 143475 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	22,576		1.00
2.00	Physician Assistant	0	85,270		2.00
3.00	Nurse Practitioner	0	103,791		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	73,920		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	8,981		9.00
10.00	Subtotal (sum of lines 1-9)	0	294,538		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	29,323		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	29,323		14.00
15.00	Medical Supplies	0	10,275		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	5,471		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	15,746		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	339,607		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	339,607		32.00

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

Provider CCN: 141300 Component CCN: 143474 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	136,124	10,181	146,305	1,000	147,305	1.00
2.00	Physician Assistant	4,145	310	4,455	0	4,455	2.00
3.00	Nurse Practitioner	36,638	2,740	39,378	1,250	40,628	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	35,266	2,637	37,903	0	37,903	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	43,001	3,216	46,217	-46,217	0	9.00
10.00	Subtotal (sum of lines 1-9)	255,174	19,084	274,258	-43,967	230,291	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	7,141	7,141	0	7,141	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	18,447	18,447	-7,817	10,630	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	25,588	25,588	-7,817	17,771	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	255,174	44,672	299,846	-51,784	248,062	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	255,174	44,672	299,846	-51,784	248,062	32.00

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

Provider CCN: 141300 | Component CCN: 143474 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	147,305		1.00
2.00	Physician Assistant	0	4,455		2.00
3.00	Nurse Practitioner	0	40,628		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	37,903		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	230,291		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	7,141		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	10,630		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	17,771		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	248,062		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	248,062		32.00

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

Provider CCN: 141300 Component CCN: 143476 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) IV | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	107,617	8,713	116,330	2,000	118,330	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	12,651	1,024	13,675	1,000	14,675	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	36,264	2,936	39,200	0	39,200	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	32,299	2,615	34,914	-10,613	24,301	9.00
10.00	Subtotal (sum of lines 1-9)	188,831	15,288	204,119	-7,613	196,506	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	12,250	12,250	0	12,250	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	12,250	12,250	0	12,250	14.00
15.00	Medical Supplies	0	4,051	4,051	0	4,051	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	17,375	17,375	-3,772	13,603	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	21,426	21,426	-3,772	17,654	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	188,831	48,964	237,795	-11,385	226,410	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	188,831	48,964	237,795	-11,385	226,410	32.00

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

Provider CCN: 141300 | Component CCN: 143476 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-1 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	118,330		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	14,675		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	39,200		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	24,301		9.00
10.00	Subtotal (sum of lines 1-9)	0	196,506		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	12,250		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	12,250		14.00
15.00	Medical Supplies	0	4,051		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	13,603		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	17,654		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	226,410		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	226,410		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-2

Component CCN: 143403 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.03	0	4,200	126		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.90	1,683	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1-3)	0.93	1,683		2,016	2,016	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.93	1,683			2,016	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					166,819	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					166,819	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					73,413	15.00
16.00	Total overhead (sum of lines 14 and 15)					73,413	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					73,413	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					73,413	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					240,232	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-2

Component CCN: 143475 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.03	1,062	4,200	126		1.00
2.00	Physician Assistant	0.91	2,236	2,100	1,911		2.00
3.00	Nurse Practitioner	1.11	2,135	2,100	2,331		3.00
4.00	Subtotal (sum of lines 1-3)	2.05	5,433		4,368	5,433	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.05	5,433			5,433	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					339,607	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					339,607	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					173,728	15.00
16.00	Total overhead (sum of lines 14 and 15)					173,728	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					173,728	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					173,728	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					513,335	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141300 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-2

Component CCN: 143474 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.71	2,484	4,200	2,982		1.00
2.00	Physician Assistant	0.05	119	2,100	105		2.00
3.00	Nurse Practitioner	0.41	971	2,100	861		3.00
4.00	Subtotal (sum of lines 1-3)	1.17	3,574		3,948	3,948	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.17	3,574			3,948	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					248,062	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					248,062	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					98,264	15.00
16.00	Total overhead (sum of lines 14 and 15)					98,264	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					98,264	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					98,264	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					346,326	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141300 | Component CCN: 143476 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-2 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.52	1,373	4,200	2,184		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.14	248	2,100	294		3.00
4.00	Subtotal (sum of lines 1-3)	0.66	1,621		2,478	2,478	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.66	1,621			2,478	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					226,410	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					226,410	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					94,247	15.00
16.00	Total overhead (sum of lines 14 and 15)					94,247	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					94,247	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					94,247	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					320,657	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141300 | Component CCN: 143403 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-3 | Date/Time Prepared: 1/30/2013 2:24 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		240,232	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		2,282	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		237,950	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,016	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,016	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		118.03	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)	118.03	118.03	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	334	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	39,422	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		39,422	16.00
16.01	Total program charges (see instructions)(from contractor's records)		26,316	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		27,754	16.04
16.05	Total program cost (see instructions)		27,754	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,730	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		4,317	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		27,754	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,693	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		29,447	22.00
23.00	Reimbursable bad debts (see instructions)		698	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		30,145	26.00
27.00	Interim payments		28,492	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		1,653	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141300 | Component CCN: 143475 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-3 | Date/Time Prepared: 1/30/2013 2:24 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		513,335	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		3,354	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		509,981	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,433	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,433	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		93.87	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)	93.87	93.87	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	645	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	60,546	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		60,546	16.00
16.01	Total program charges (see instructions)(from contractor's records)		53,932	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		42,060	16.04
16.05	Total program cost (see instructions)		42,060	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,971	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,192	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		42,060	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		925	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		42,985	22.00
23.00	Reimbursable bad debts (see instructions)		467	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		43,452	26.00
27.00	Interim payments		42,793	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		659	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141300 | Component CCN: 143474 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-3 | Date/Time Prepared: 1/30/2013 2:24 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		346,326	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		6,553	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		339,773	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,948	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,948	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		86.06	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)	86.06	86.06	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,292	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	111,190	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		111,190	16.00
16.01	Total program charges (see instructions)(from contractor's records)		107,357	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		75,654	16.04
16.05	Total program cost (see instructions)		75,654	16.05
17.00	Primary payer amounts		69	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,622	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,147	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		75,585	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,347	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		79,932	22.00
23.00	Reimbursable bad debts (see instructions)		398	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		80,330	26.00
27.00	Interim payments		73,071	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		7,259	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141300 | Component CCN: 143476 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-3 | Date/Time Prepared: 1/30/2013 2:24 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		320,657	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		3,625	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		317,032	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,478	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,478	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		127.94	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	999.00	999.00	8.00
9.00	Rate for Program covered visits (see instructions)	127.94	127.94	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	661	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	84,568	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		84,568	16.00
16.01	Total program charges (see instructions)(from contractor's records)		54,399	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		60,611	16.04
16.05	Total program cost (see instructions)		60,611	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,804	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		9,119	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		60,611	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,086	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		63,697	22.00
23.00	Reimbursable bad debts (see instructions)		484	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		64,181	26.00
27.00	Interim payments		63,912	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		269	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141300 | Component CCN: 143403 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-4 | Date/Time Prepared: 1/30/2013 2:24 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	144,068	144,068	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000297	0.006684	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	43	963	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	40	538	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	83	1,501	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	166,819	166,819	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	73,413	73,413	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000498	0.008998	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	37	661	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	120	2,162	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	2	45	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	60.00	48.04	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	34	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	60	1,633	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		2,282	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,693	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141300 | Component CCN: 143475 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-4 | Date/Time Prepared: 1/30/2013 2:24 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	294,538	294,538	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.004003	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	1,179	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	1,040	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	2,219	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	339,607	339,607	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	173,728	173,728	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.006534	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	1,135	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	3,354	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	87	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	38.55	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	24	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	925	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		3,354	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		925	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141300 | Component CCN: 143474 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-4 | Date/Time Prepared: 1/30/2013 2:24 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	230,291	230,291	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000769	0.010702	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	177	2,465	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	223	1,829	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	400	4,294	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	248,062	248,062	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	98,264	98,264	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001613	0.017310	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	158	1,701	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	558	5,995	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	11	153	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	50.73	39.18	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	10	98	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	507	3,840	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		6,553	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		4,347	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141300 | Component CCN: 143476 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-4 | Date/Time Prepared: 1/30/2013 2:24 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	196,506	196,506	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000463	0.008791	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	91	1,727	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	61	681	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	152	2,408	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	226,410	226,410	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	94,247	94,247	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000671	0.010636	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	63	1,002	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	215	3,410	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	3	57	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	71.67	59.82	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	3	48	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	215	2,871	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		3,625	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		3,086	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141300 Component CCN: 143403 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-5 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		21,470	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/24/2012	3,729	3.01
3.02		08/27/2012	3,293	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		7,022	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		28,492	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,653	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		30,145	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141300 Component CCN: 143475 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-5 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		38,953	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/24/2012	2,342	3.01
3.02		08/27/2012	1,498	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,840	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		42,793	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		659	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		43,452	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141300 Component CCN: 143474 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-5 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		66,979	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/24/2012	6,092	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		6,092	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		73,071	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		7,259	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		80,330	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141300 | Component CCN: 143476 | Period: From 09/01/2011 To 08/31/2012 | Worksheet M-5 | Date/Time Prepared: 1/30/2013 2:24 pm

Rural Health Clinic (RHC) IV | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		64,107	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50		02/24/2012	195	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-195	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		63,912	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		269	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		64,181	7.00

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