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: 141323	Period: From 04/01/2011 To 03/31/2012	Worksheet S Parts I-III Date/Time Prepared: 8/29/2012 12:11 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/29/2012 Time: 12:11 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 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 MASSAC MEMORIAL HOSPITAL for the cost reporting period beginning 04/01/2011 and ending 03/31/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	398,382	166,567	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	53,430	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		-8,629		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	451,812	157,938	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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 8/29/2012 9:24 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 28 CHICK STREET	PO Box:			1.00
2.00	City: METROPOLIS	State: IL	Zip Code: 62960-	County: MASSAC	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	MASSAC MEMORIAL HOSPITAL	141323	99916	1	02/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MASSAC MEMORIAL HOSPITAL	14Z323	99916		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MASSAC MEMORIAL MEDICAL CLINIC	143478	99916		02/07/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2011	03/31/2012	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	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 days	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 days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible 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 days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible 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

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

		Beginning:	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141323	Period: From 04/01/2011 To 03/31/2012	Worksheet S-2 Part I Date/Time Prepared: 8/29/2012 9:24 am

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

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

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no 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	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 8/29/2012 9:24 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 8/29/2012 9:24 am

		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	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N	86.00

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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	N	N	N	109.00

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 8/29/2012 9:24 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	157,804	0	0	118.01

		1.00	2.00	
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, 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	N	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 8/29/2012 9:24 am

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	

Multicampus

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
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
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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 8/29/2012 9:24 am

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

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

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

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	05/15/2012	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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 8/29/2012 9:24 am

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		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	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.	GWEN	MOSER	PARTNER		41.00
42.00	Enter the employer/company name of the cost report preparer.	EIDE BAILLY LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-556-1790	GMOSER@EIDEBAILLY.COM			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 8/29/2012 9:24 am

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/15/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	85,040.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	85,040.00		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,150	85,040.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	2,602	307	3,546		1.00
2.00	HMO		30	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	436	0	465		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	14		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,038	307	4,025		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0	3,038	307	4,025		14.00
15.00	CAH visits	0	9,901	9,092	28,470		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	1,218	0	9,715		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	236		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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	649	1.00
2.00	HMO					0	2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	175.87	0.00	0	649	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00	8.20	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	184.07	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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	168	1,118		1.00
2.00	HMO				2.00
3.00	HMO IPF				3.00
4.00	HMO IRF				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				5.00
6.00	Hospital Adults & Peds. Swing Bed NF				6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00	INTENSIVE CARE UNIT				8.00
9.00	CORONARY CARE UNIT				9.00
10.00	BURN INTENSIVE CARE UNIT				10.00
11.00	SURGICAL INTENSIVE CARE UNIT				11.00
12.00	OTHER SPECIAL CARE (SPECIFY)				12.00
13.00	NURSERY				13.00
14.00	Total (see instructions)	168	1,118		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

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

Provider CCN: 141323 Component CCN: 143478

Period: From 04/01/2011 To 03/31/2012

Worksheet S-8

Date/Time Prepared: 8/29/2012 9:24 am

		Rural Health Clinic (RHC) I	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	28 CHICK STREET		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	METROPOLIS	IL	62960 2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic			08:30	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. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

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

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

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

Provider CCN: 141323
Component CCN: 143478

Period:
From 04/01/2011
To 03/31/2012

Worksheet S-8

Date/Time Prepared:
8/29/2012 9:24 am

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		MASSAC				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	08:30	18:00	08:30	18:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141323 Component CCN: 143478	Period: From 04/01/2011 To 03/31/2012	Worksheet S-8 Date/Time Prepared: 8/29/2012 9:24 am
		Rural Health Clinic (RHC) I	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:30	18:00	08:30	18:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141323 Component CCN: 143478	Period: From 04/01/2011 To 03/31/2012	Worksheet S-8 Date/Time Prepared: 8/29/2012 9:24 am
		Rural Health Clinic (RHC) I	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-10 | Date/Time Prepared: 8/29/2012 9:24 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.453317	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,456,879	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	9,591,274	6.00
7.00	Medicaid cost (line 1 times line 6)	4,347,888	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,891,009	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,891,009	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	907,875	0	907,875	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	411,555	0	411,555	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	411,555	0	411,555	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,221,301	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	780,862	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	2,440,439	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,106,292	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,517,847	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,408,856	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A | Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		859,807	859,807	427,416	1,287,223	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		0	0	26,000	26,000	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		0	0	15,600	15,600	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		636,319	636,319	129,138	765,457	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		9,377	9,377	-9,377	0	3.00
4.00	00400	EMPLOYEE BENEFITS	104,174	2,871,771	2,975,945	0	2,975,945	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	944,178	1,183,875	2,128,053	-241,067	1,886,986	5.00
7.00	00700	OPERATION OF PLANT	272,657	646,314	918,971	-21,265	897,706	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,275	99,310	112,585	0	112,585	8.00
9.00	00900	HOUSEKEEPING	288,517	61,848	350,365	0	350,365	9.00
10.00	01000	DIETARY	274,133	192,173	466,306	-156,356	309,950	10.00
11.00	01100	CAFETERIA	0	0	0	155,554	155,554	11.00
13.00	01300	NURSING ADMINISTRATION	483,809	15,946	499,755	0	499,755	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	235,359	29,604	264,963	0	264,963	16.00
17.00	01700	SOCIAL SERVICE	149,020	7,529	156,549	0	156,549	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,445,275	290,640	1,735,915	0	1,735,915	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	286,153	233,172	519,325	-106,434	412,891	50.00
53.00	05300	ANESTHESIOLOGY	0	324,445	324,445	0	324,445	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	568,787	525,843	1,094,630	-532	1,094,098	54.00
60.00	06000	LABORATORY	487,671	606,899	1,094,570	-39,694	1,054,876	60.00
65.00	06500	RESPIRATORY THERAPY	292,729	96,402	389,131	-23,917	365,214	65.00
66.00	06600	PHYSICAL THERAPY	412,615	14,552	427,167	-476	426,691	66.00
69.00	06900	ELECTROCARDIOLOGY	81,956	177,154	259,110	-478	258,632	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,277	20,725	94,002	42,318	136,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	48,262	48,262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	224,687	439,508	664,195	-3,892	660,303	73.00
76.00	03020	GERIATRIC PSYCH	190,153	113,538	303,691	0	303,691	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	471,873	254,802	726,675	44,133	770,808	88.00
91.00	09100	EMERGENCY	670,135	578,525	1,248,660	114,511	1,363,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	468,039	125,004	593,043	-26,000	567,043	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		524,163	524,163	-524,163	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,438,472	10,939,245	19,377,717	-150,719	19,226,998	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,323	3,750	22,073	107,729	129,802	192.00
192.01	19201	PROMOTION	0	0	0	42,990	42,990	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	8,456,795	10,942,995	19,399,790	0	19,399,790	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A | Date/Time Prepared: 8/29/2012 9:24 am

		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	-117,364	1,169,859		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	26,000		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	15,600		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-10,657	754,800		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS	-236	2,975,709		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-18,095	1,868,891		5.00
7.00	00700	OPERATION OF PLANT	-5,031	892,675		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	112,585		8.00
9.00	00900	HOUSEKEEPING	0	350,365		9.00
10.00	01000	DIETARY	-802	309,148		10.00
11.00	01100	CAFETERIA	-72,930	82,624		11.00
13.00	01300	NURSING ADMINISTRATION	0	499,755		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,092	263,871		16.00
17.00	01700	SOCIAL SERVICE	0	156,549		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-150,741	1,585,174		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	412,891		50.00
53.00	05300	ANESTHESIOLOGY	-324,445	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,094,098		54.00
60.00	06000	LABORATORY	0	1,054,876		60.00
65.00	06500	RESPIRATORY THERAPY	0	365,214		65.00
66.00	06600	PHYSICAL THERAPY	0	426,691		66.00
69.00	06900	ELECTROCARDIOLOGY	-104,320	154,312		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-4,378	131,942		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,262		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,019	658,284		73.00
76.00	03020	GERIATRIC PSYCH	0	303,691		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	770,808		88.00
91.00	09100	EMERGENCY	-73,221	1,289,950		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	567,043		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-885,331	18,341,667		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	129,802		192.00
192.01	19201	PROMOTION	0	42,990		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-885,331	18,514,459		200.00

RECLASSIFICATIONS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-6 | Date/Time Prepared: 8/29/2012 9:24 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	494,624		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	29,539		2.00
	TOTALS		0	524,163		
	B - TO RECLASS CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	91,447	64,107		1.00
	TOTALS		91,447	64,107		
	C - TO RECLASS RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	97,410		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		0	97,410		
	D - TO RECLASS MEDICAL SUPPLY EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	47,687		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,769		7.00
	TOTALS		0	50,456		
	E - TO RECLASS DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	802		1.00
	TOTALS		0	802		
	F - TO RECLASS PROF BUILD COSTS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	74,396		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	74,396		
	G - TO RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	20,271	0		1.00
	TOTALS		20,271	0		
	H - RECLASS IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	48,262		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	48,262		
	I - TO RECLASS RHC PHYSICIAN RECRUITMENT					
1.00	RURAL HEALTH CLINIC	88.00	0	44,133		1.00
	TOTALS		0	44,133		
	J - TO RECLASS PROFESSIONAL BUILDING CST					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	20,725		1.00
	TOTALS		0	20,725		
	M - TO RECLASS REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,985		1.00
	TOTALS		0	12,985		
	N - TO RECLASS ER PHY MALPRACTICE					
1.00	EMERGENCY	91.00	0	132,096		1.00
	TOTALS		0	132,096		
	O - TO RECLASS AMBULANCE RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	26,000		1.00
	TOTALS		0	26,000		
	P - TO RECLASS SLEEP LAB RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-BLDG EKG	1.02	0	15,600		1.00
	TOTALS		0	15,600		
	U - TO RECLASS MARKETING EXPENSES					
1.00	PROMOTION	192.01	0	42,990		1.00
	TOTALS		0	42,990		
	V - A-8 SALARY FOR B-1 PURPOSES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	870		1.00
	TOTALS		0	870		
500.00	Grand Total: Increases		111,718	1,154,995		500.00

RECLASSIFICATIONS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-6 | Date/Time Prepared: 8/29/2012 9:24 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	524,163	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	524,163			
	B - TO RECLASS CAFETERIA EXPENSE						
1.00	DIETARY	10.00	91,447	64,107	0		1.00
	TOTALS		91,447	64,107			
	C - TO RECLASS RENTAL EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,863	10		1.00
2.00	OPERATION OF PLANT	7.00	0	540	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,301	0		3.00
4.00	LABORATORY	60.00	0	39,694	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	3,646	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	261	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	5,091	0		7.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	377	0		9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	911	0		10.00
11.00	OPERATING ROOM	50.00	0	34,726	0		11.00
	TOTALS		0	97,410			
	D - TO RECLASS MEDICAL SUPPLY EXPENSE						
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	0	25,135	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	215	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	0	58	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,694	0		5.00
6.00	EMERGENCY	91.00	0	17,585	0		6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,769	0		7.00
	TOTALS		0	50,456			
	E - TO RECLASS DRUG COSTS						
1.00	DIETARY	10.00	0	802	0		1.00
	TOTALS		0	802			
	F - TO RECLASS PROF BUILD COSTS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	74,159	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	237	9		2.00
	TOTALS		0	74,396			
	G - TO RECLASS EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	20,271	0	0		1.00
	TOTALS		20,271	0			
	H - RECLASS IMPLANTABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,689	0		1.00
2.00	OPERATING ROOM	50.00	0	46,573	0		2.00
	TOTALS		0	48,262			
	I - TO RECLASS RHC PHYSICIAN RECRUITMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	44,133	0		1.00
	TOTALS		0	44,133			
	J - TO RECLASS PROFESSIONAL BUILDING CST						
1.00	OPERATION OF PLANT	7.00	0	20,725	0		1.00
	TOTALS		0	20,725			
	M - TO RECLASS REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,985	0		1.00
	TOTALS		0	12,985			
	N - TO RECLASS ER PHY MALPRACTICE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	132,096	0		1.00
	TOTALS		0	132,096			
	O - TO RECLASS AMBULANCE RENTAL EXPENSE						
1.00	AMBULANCE SERVICES	95.00	0	26,000	10		1.00
	TOTALS		0	26,000			
	P - TO RECLASS SLEEP LAB RENTAL EXPENSE						
1.00	ELECTROCARDIOLOGY	69.00	0	15,600	10		1.00
	TOTALS		0	15,600			
	U - TO RECLASS MARKETING EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,990	0		1.00
	TOTALS		0	42,990			
	V - A-8 SALARY FOR B-1 PURPOSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	870	0	0		1.00
	TOTALS		870	0			
500.00	Grand Total: Decreases		112,588	1,154,125			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 8/29/2012 9:24 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	13,980	0	0	0	0	1.00
2.00	Land Improvements	1,055,937	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,063,150	1,167,352	0	1,167,352	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,906,164	269,922	0	269,922	91,555	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,039,231	1,437,274	0	1,437,274	91,555	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,039,231	1,437,274	0	1,437,274	91,555	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	859,807	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	636,319	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,496,126	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	20,300,419	0	20,300,419	0.741298	6,951	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,084,531	0	7,084,531	0.258702	2,426	2.00
3.00	Total (sum of lines 1-2)	27,384,950	0	27,384,950	1.000000	9,377	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 8/29/2012 9:24 am

		Ending Balance	Fully Depreciated Assets		
		6.00	7.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES				
1.00	Land	13,980	0		1.00
2.00	Land Improvements	1,055,937	0		2.00
3.00	Buildings and Fixtures	19,230,502	0		3.00
4.00	Building Improvements	0	0		4.00
5.00	Fixed Equipment	0	0		5.00
6.00	Movable Equipment	7,084,531	0		6.00
7.00	HIT designated Assets	0	0		7.00
8.00	Subtotal (sum of lines 1-7)	27,384,950	0		8.00
9.00	Reconciling Items	0	0		9.00
10.00	Total (line 8 minus line 9)	27,384,950	0		10.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	859,807		1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0		1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0		1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	636,319		2.00
3.00	Total (sum of lines 1-2)	0	1,496,126		3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	6,951	785,648	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	26,000	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	15,600	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2,426	632,434	97,410	2.00
3.00	Total (sum of lines 1-2)	0	0	9,377	1,418,082	139,010	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	377,260	6,951	0	0	1,169,859	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	26,000	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	15,600	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	22,530	2,426	0	0	754,800	2.00
3.00	Total (sum of lines 1-2)	399,790	9,377	0	0	1,966,259	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8 | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-117,364	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)		0	NEW CAP REL COSTS-BLDG EKG	1.02	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-7,009	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,593	ADMINISTRATIVE & GENERAL	5.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-328,282			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		0		0.00	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	A	-1,092	MEDICAL RECORDS & LIBRARY	16.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01	Depreciation - NEW CAP REL COSTS-BLDG AMBULANCE		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG		0	NEW CAP REL COSTS-BLDG EKG	1.02	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	TELEVISION	A	-5,031	OPERATION OF PLANT	7.00	33.00
34.00	OTHER OPERATING REVENUE	B	1,334	ADMINISTRATIVE & GENERAL	5.00	34.00
35.00	OTHER NON OPERATING REVENUE	B	-5,400	ADMINISTRATIVE & GENERAL	5.00	35.00
36.00	ACCOUNTS PAYABLE DISCOUNT	B	-1,391	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	PHARMACY REBATES	B	-2,019	DRUGS CHARGED TO PATIENTS	73.00	37.00
38.00	PURCHASING REBATES	B	-4,378	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	38.00
39.00	DIETARY REVENUE	B	-72,930	CAFETERIA	11.00	39.00
40.00			0		0.00	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	41.00
42.00	LOBBYING EXPENSE	A	-2,510	ADMINISTRATIVE & GENERAL	5.00	42.00
43.00	CRNA EXPENSES	A	-324,445	ANESTHESIOLOGY	53.00	43.00
44.00	DIETARY REBATES	B	-802	DIETARY	10.00	44.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8 | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
45.00	COMMUNITY OUTREACH	A	-1,640	ADMINISTRATIVE & GENERAL	5.00	45.00
45.01	PATIENT TV DEPRECIATION	A	-1,357	NEW CAP REL COSTS-MVBLE EQUIP	2.00	45.01
45.02	PATIENT PHONE SALARY	A	-870	ADMINISTRATIVE & GENERAL	5.00	45.02
45.03	PATIENT PHONE BENEFITS	A	-236	EMPLOYEE BENEFITS	4.00	45.03
45.04	PATIENT PHONE DEPRECIATION	A	-2,291	NEW CAP REL COSTS-MVBLE EQUIP	2.00	45.04
45.05			0		0.00	45.05
45.06	X-RAY FILM COPIES	B	-25	ADMINISTRATIVE & GENERAL	5.00	45.06
45.07			0		0.00	45.07
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-885,331			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8 | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	11		1.00
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)	0		1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)	0		1.02
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 - NEW CAP REL COSTS-BLDG AMBULANCE	0		26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG	0		26.02
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	TELEVISION	0		33.00
34.00	OTHER OPERATING REVENUE	0		34.00
35.00	OTHER NON OPERATING REVENUE	0		35.00
36.00	ACCOUNTS PAYABLE DISCOUNT	0		36.00
37.00	PHARMACY REBATES	0		37.00
38.00	PURCHASING REBATES	0		38.00
39.00	DIETARY REVENUE	0		39.00
40.00		0		40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)	0		41.00
42.00	LOBBYING EXPENSE	0		42.00
43.00	CRNA EXPENSES	0		43.00
44.00	DIETARY REBATES	0		44.00
45.00	COMMUNITY OUTREACH	0		45.00
45.01	PATIENT TV DEPRECIATION	9		45.01
45.02	PATIENT PHONE SALARY	0		45.02
45.03	PATIENT PHONE BENEFITS	0		45.03
45.04	PATIENT PHONE DEPRECIATION	9		45.04
45.05		0		45.05
45.06	X-RAY FILM COPIES	0		45.06
45.07		0		45.07

ADJUSTMENTS TO EXPENSES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8 | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	Wkst. A-7 Ref.		
		5.00		
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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 8/29/2012 9:24 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		60.00	LABORATORY	12,000	0	1.00
2.00		69.00	ELECTROCARDIOLOGY	104,320	104,320	2.00
3.00		91.00	EMERGENCY	470,696	0	3.00
4.00		30.00	ADULTS & PEDIATRICS	150,741	150,741	4.00
5.00		69.00	ELECTROCARDIOLOGY	13,200	0	5.00
6.00		69.00	ELECTROCARDIOLOGY	23,528	0	6.00
7.00		91.00	EMERGENCY	132,096	73,221	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				906,581	328,282	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 8/29/2012 9:24 am

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		12,000	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		470,696	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		13,200	0	0	0	0	5.00
6.00		23,528	0	0	0	0	6.00
7.00		58,875	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		578,299		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 8/29/2012 9:24 am

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 8/29/2012 9:24 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	0		1.00
2.00		0	104,320		2.00
3.00		0	0		3.00
4.00		0	150,741		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	73,221		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	328,282		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part I Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,169,859	1,169,859				1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	26,000	0	26,000			1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	15,600	0	0	15,600		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	754,800				754,800	2.00
4.00	00400	EMPLOYEE BENEFITS	2,975,709	5,591	0	0	3,415	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,868,891	292,488	0	0	178,630	5.00
7.00	00700	OPERATION OF PLANT	892,675	107,416	0	0	65,602	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	112,585	22,365	0	0	13,659	8.00
9.00	00900	HOUSEKEEPING	350,365	8,235	0	0	5,029	9.00
10.00	01000	DIETARY	309,148	26,923	0	0	16,443	10.00
11.00	01100	CAFETERIA	82,624	11,265	0	0	6,880	11.00
13.00	01300	NURSING ADMINISTRATION	499,755	4,682	0	0	2,860	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	263,871	21,194	0	1,824	14,559	16.00
17.00	01700	SOCIAL SERVICE	156,549	2,493	0	0	1,522	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,585,174	202,604	0	0	123,735	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	412,891	124,341	0	0	75,938	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,094,098	67,438	0	0	41,186	54.00
60.00	06000	LABORATORY	1,054,876	16,402	0	0	10,017	60.00
65.00	06500	RESPIRATORY THERAPY	365,214	22,681	0	0	13,852	65.00
66.00	06600	PHYSICAL THERAPY	426,691	23,700	0	0	14,474	66.00
69.00	06900	ELECTROCARDIOLOGY	154,312	22,475	0	13,776	25,921	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	131,942	19,032	0	0	11,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,262	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	658,284	7,850	0	0	4,794	73.00
76.00	03020	GERIATRIC PSYCH	303,691	16,030	0	0	9,790	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	770,808	61,544	0	0	37,587	88.00
91.00	09100	EMERGENCY	1,289,950	80,783	0	0	49,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	567,043	0	26,000	0	26,527	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,341,667	1,167,532	26,000	15,600	753,379	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,327	0	0	1,421	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	129,802	0	0	0	0	192.00
192.01	19201	PROMOTION	42,990	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	18,514,459	1,169,859	26,000	15,600	754,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part I Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	2,984,715					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	337,116	2,677,125	2,677,125			5.00
7.00	00700	OPERATION OF PLANT	97,441	1,163,134	196,615	1,359,749		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,744	153,353	25,923	39,785	219,061	8.00
9.00	00900	HOUSEKEEPING	103,109	466,738	78,897	14,650	0	9.00
10.00	01000	DIETARY	65,288	417,802	70,625	47,894	0	10.00
11.00	01100	CAFETERIA	32,681	133,450	22,558	20,040	0	11.00
13.00	01300	NURSING ADMINISTRATION	172,902	680,199	114,980	8,329	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84,112	385,560	65,175	37,703	0	16.00
17.00	01700	SOCIAL SERVICE	53,256	213,820	36,144	4,434	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	516,506	2,428,019	410,428	360,417	133,810	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	102,264	715,434	120,936	221,194	11,141	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	203,271	1,405,993	237,668	119,968	21,313	54.00
60.00	06000	LABORATORY	174,282	1,255,577	212,241	29,177	0	60.00
65.00	06500	RESPIRATORY THERAPY	97,370	499,117	84,370	40,349	484	65.00
66.00	06600	PHYSICAL THERAPY	147,459	612,324	103,507	42,161	5,207	66.00
69.00	06900	ELECTROCARDIOLOGY	36,533	253,017	42,770	39,981	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,187	188,784	31,912	33,857	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,262	8,158	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,298	751,226	126,986	13,964	0	73.00
76.00	03020	GERIATRIC PSYCH	67,956	397,467	67,187	28,516	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	168,636	1,038,575	175,560	109,483	0	88.00
91.00	09100	EMERGENCY	239,490	1,659,559	280,530	143,707	46,137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	167,266	786,836	133,006	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,978,167	18,331,371	2,646,176	1,355,609	218,092	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,748	634	4,140	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,548	136,350	23,048	0	969	192.00
192.01	19201	PROMOTION	0	42,990	7,267	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	2,984,715	18,514,459	2,677,125	1,359,749	219,061	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part I Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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	560,285					9.00
10.00	01000	DIETARY	9,907	546,228				10.00
11.00	01100	CAFETERIA	11,417	0	187,465			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	8,898	812,406		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,049	0	9,044	0	502,531	16.00
17.00	01700	SOCIAL SERVICE	0	0	3,058	30,228	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	259,937	311,442	45,732	451,978	231,434	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,851	0	7,690	75,998	48,921	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,254	0	14,986	0	0	54.00
60.00	06000	LABORATORY	22,921	0	16,457	0	54,832	60.00
65.00	06500	RESPIRATORY THERAPY	19,555	0	10,224	0	54,832	65.00
66.00	06600	PHYSICAL THERAPY	16,102	0	9,423	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	8,415	0	1,587	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,986	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,696	0	3,728	36,850	0	73.00
76.00	03020	GERIATRIC PSYCH	0	52,571	5,505	54,407	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	28,595	0	11,520	0	0	88.00
91.00	09100	EMERGENCY	85,749	0	19,253	0	112,512	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	16,486	162,945	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	512,448	364,013	186,577	812,406	502,531	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,837	182,215	888	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	560,285	546,228	187,465	812,406	502,531	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part I Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	287,684					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	287,684	0	4,920,881	-189,979	4,730,902	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,213,165	0	1,213,165	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,829,182	0	1,829,182	54.00
60.00	06000	LABORATORY	0	0	1,591,205	34,887	1,626,092	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	708,931	0	708,931	65.00
66.00	06600	PHYSICAL THERAPY	0	0	788,724	0	788,724	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	345,770	0	345,770	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	257,539	0	257,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	56,420	0	56,420	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	936,450	0	936,450	73.00
76.00	03020	GERIATRIC PSYCH	0	0	605,653	0	605,653	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,363,733	0	1,363,733	88.00
91.00	09100	EMERGENCY	0	0	2,347,447	-742	2,346,705	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	155,834	155,834	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	1,099,273	0	1,099,273	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	287,684	0	18,064,373	0	18,064,373	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	8,522	0	8,522	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	391,307	0	391,307	192.00
192.01	19201	PROMOTION	0	0	50,257	0	50,257	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	287,684	0	18,514,459	0	18,514,459	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part II Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	5,591	0	0	3,415	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	292,488	0	0	178,630	5.00
7.00	00700	OPERATION OF PLANT	0	107,416	0	0	65,602	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,365	0	0	13,659	8.00
9.00	00900	HOUSEKEEPING	0	8,235	0	0	5,029	9.00
10.00	01000	DIETARY	0	26,923	0	0	16,443	10.00
11.00	01100	CAFETERIA	0	11,265	0	0	6,880	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,682	0	0	2,860	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,194	0	1,824	14,559	16.00
17.00	01700	SOCIAL SERVICE	0	2,493	0	0	1,522	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	202,604	0	0	123,735	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	124,341	0	0	75,938	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,438	0	0	41,186	54.00
60.00	06000	LABORATORY	0	16,402	0	0	10,017	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,681	0	0	13,852	65.00
66.00	06600	PHYSICAL THERAPY	0	23,700	0	0	14,474	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,475	0	13,776	25,921	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,032	0	0	11,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,850	0	0	4,794	73.00
76.00	03020	GERIATRIC PSYCH	0	16,030	0	0	9,790	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	61,544	0	0	37,587	88.00
91.00	09100	EMERGENCY	0	80,783	0	0	49,336	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	26,000	0	26,527	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,167,532	26,000	15,600	753,379	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,327	0	0	1,421	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	0	1,169,859	26,000	15,600	754,800	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part II Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	9,006	9,006				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	471,118	1,017	472,135			5.00
7.00	00700	OPERATION OF PLANT	173,018	294	34,675	207,987		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,024	14	4,572	6,086	46,696	8.00
9.00	00900	HOUSEKEEPING	13,264	311	13,914	2,241	0	9.00
10.00	01000	DIETARY	43,366	197	12,456	7,326	0	10.00
11.00	01100	CAFETERIA	18,145	99	3,978	3,065	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,542	522	20,278	1,274	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	37,577	254	11,494	5,767	0	16.00
17.00	01700	SOCIAL SERVICE	4,015	161	6,374	678	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	326,339	1,559	72,376	55,129	28,523	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	200,279	308	21,329	33,834	2,375	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,624	613	41,915	18,350	4,543	54.00
60.00	06000	LABORATORY	26,419	526	37,431	4,463	0	60.00
65.00	06500	RESPIRATORY THERAPY	36,533	294	14,880	6,172	103	65.00
66.00	06600	PHYSICAL THERAPY	38,174	445	18,255	6,449	1,110	66.00
69.00	06900	ELECTROCARDIOLOGY	62,172	110	7,543	6,116	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,655	79	5,628	5,179	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,439	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,644	242	22,396	2,136	0	73.00
76.00	03020	GERIATRIC PSYCH	25,820	205	11,849	4,362	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	99,131	509	30,962	16,746	0	88.00
91.00	09100	EMERGENCY	130,119	722	49,475	21,981	9,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	52,527	505	23,457	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,962,511	8,986	466,676	207,354	46,489	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,748	0	112	633	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20	4,065	0	207	192.00
192.01	19201	PROMOTION	0	0	1,282	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	1,966,259	9,006	472,135	207,987	46,696	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part II Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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	29,730					9.00
10.00	01000	DIETARY	526	63,871				10.00
11.00	01100	CAFETERIA	606	0	25,893			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,229	30,845		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268	0	1,249	0	56,609	16.00
17.00	01700	SOCIAL SERVICE	0	0	422	1,148	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,793	36,417	6,319	17,160	26,070	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	629	0	1,062	2,885	5,511	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,552	0	2,070	0	0	54.00
60.00	06000	LABORATORY	1,216	0	2,273	0	6,177	60.00
65.00	06500	RESPIRATORY THERAPY	1,038	0	1,412	0	6,177	65.00
66.00	06600	PHYSICAL THERAPY	854	0	1,301	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	447	0	219	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	412	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	196	0	515	1,399	0	73.00
76.00	03020	GERIATRIC PSYCH	0	6,147	760	2,066	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,517	0	1,591	0	0	88.00
91.00	09100	EMERGENCY	4,550	0	2,659	0	12,674	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	2,277	6,187	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,192	42,564	25,770	30,845	56,609	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,538	21,307	123	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	29,730	63,871	25,893	30,845	56,609	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part II Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	12,798					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,798		596,483	0	596,483	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		268,212	0	268,212	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		177,667	0	177,667	54.00
60.00	06000	LABORATORY	0		78,505	0	78,505	60.00
65.00	06500	RESPIRATORY THERAPY	0		66,609	0	66,609	65.00
66.00	06600	PHYSICAL THERAPY	0		66,588	0	66,588	66.00
69.00	06900	ELECTROCARDIOLOGY	0		76,607	0	76,607	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		41,953	0	41,953	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		1,439	0	1,439	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		39,528	0	39,528	73.00
76.00	03020	GERIATRIC PSYCH	0		51,209	0	51,209	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		150,456	0	150,456	88.00
91.00	09100	EMERGENCY	0		232,015	0	232,015	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		84,953	0	84,953	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,798	0	1,932,224	0	1,932,224	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		4,493	0	4,493	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		28,260	0	28,260	192.00
192.01	19201	PROMOTION	0		1,282	0	1,282	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
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)	12,798	0	1,966,259	0	1,966,259	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B-1 | Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG AMBULANCE (SQUARE FEET)	NEW BLDG EKG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	84,949					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	3,154				1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	1,642			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				89,745		2.00
4.00	00400	EMPLOYEE BENEFITS	406	0	0	406	8,351,751	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,239	0	0	21,239	943,308	5.00
7.00	00700	OPERATION OF PLANT	7,800	0	0	7,800	272,657	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,624	0	0	1,624	13,275	8.00
9.00	00900	HOUSEKEEPING	598	0	0	598	288,517	9.00
10.00	01000	DIETARY	1,955	0	0	1,955	182,686	10.00
11.00	01100	CAFETERIA	818	0	0	818	91,447	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	340	483,809	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539	0	192	1,731	235,359	16.00
17.00	01700	SOCIAL SERVICE	181	0	0	181	149,020	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,712	0	0	14,712	1,445,275	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,029	0	0	9,029	286,153	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,897	0	0	4,897	568,787	54.00
60.00	06000	LABORATORY	1,191	0	0	1,191	487,671	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,647	272,458	65.00
66.00	06600	PHYSICAL THERAPY	1,721	0	0	1,721	412,615	66.00
69.00	06900	ELECTROCARDIOLOGY	1,632	0	1,450	3,082	102,227	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,382	0	0	1,382	73,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570	0	0	570	224,687	73.00
76.00	03020	GERIATRIC PSYCH	1,164	0	0	1,164	190,153	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,469	0	0	4,469	471,873	88.00
91.00	09100	EMERGENCY	5,866	0	0	5,866	670,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,154	0	3,154	468,039	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	84,780	3,154	1,642	89,576	8,333,428	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	169	0	0	169	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	18,323	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,169,859	26,000	15,600	754,800	2,984,715	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.771310	8.243500	9.500609	8.410496	0.357376	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,006	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.001078	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B-1 | Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	
			5A	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	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,677,125	15,837,334				5.00
7.00	00700	OPERATION OF PLANT	0	1,163,134	55,504			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	153,353	1,624	1,809		8.00
9.00	00900	HOUSEKEEPING	0	466,738	598	0	161,455	9.00
10.00	01000	DIETARY	0	417,802	1,955	0	2,855	10.00
11.00	01100	CAFETERIA	0	133,450	818	0	3,290	11.00
13.00	01300	NURSING ADMINISTRATION	0	680,199	340	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	385,560	1,539	0	1,455	16.00
17.00	01700	SOCIAL SERVICE	0	213,820	181	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,428,019	14,712	1,105	74,905	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	715,434	9,029	92	3,415	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,405,993	4,897	176	8,430	54.00
60.00	06000	LABORATORY	0	1,255,577	1,191	0	6,605	60.00
65.00	06500	RESPIRATORY THERAPY	0	499,117	1,647	4	5,635	65.00
66.00	06600	PHYSICAL THERAPY	0	612,324	1,721	43	4,640	66.00
69.00	06900	ELECTROCARDIOLOGY	0	253,017	1,632	0	2,425	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	188,784	1,382	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,262	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	751,226	570	0	1,065	73.00
76.00	03020	GERIATRIC PSYCH	0	397,467	1,164	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,038,575	4,469	0	8,240	88.00
91.00	09100	EMERGENCY	0	1,659,559	5,866	381	24,710	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	786,836	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,677,125	15,654,246	55,335	1,801	147,670	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,748	169	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	136,350	0	8	13,785	192.00
192.01	19201	PROMOTION	0	42,990	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)		2,677,125	1,359,749	219,061	560,285	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.169039	24.498216	121.095080	3.470224	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		472,135	207,987	46,696	29,730	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.029812	3.747243	25.813156	0.184138	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B-1 | Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING FTES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNEDTIMES)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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	41,956					10.00
11.00	01100	CAFETERIA	0	12,872				11.00
13.00	01300	NURSING ADMINISTRATION	0	611	117,395			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	621	0	7,057		16.00
17.00	01700	SOCIAL SERVICE	0	210	4,368	0	4,300	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,922	3,140	65,312	3,250	4,300	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	528	10,982	687	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,029	0	0	0	54.00
60.00	06000	LABORATORY	0	1,130	0	770	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	702	0	770	0	65.00
66.00	06600	PHYSICAL THERAPY	0	647	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	109	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	205	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	256	5,325	0	0	73.00
76.00	03020	GERIATRIC PSYCH	4,038	378	7,862	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	791	0	0	0	88.00
91.00	09100	EMERGENCY	0	1,322	0	1,580	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,132	23,546	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,960	12,811	117,395	7,057	4,300	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,996	61	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	546,228	187,465	812,406	502,531	287,684	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.019068	14.563782	6.920278	71.210288	66.903256	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	63,871	25,893	30,845	56,609	12,798	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.522333	2.011576	0.262745	8.021681	2.976279	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B-1 | Date/Time Prepared: 8/29/2012 9:24 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		1.02
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	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	GERIATRIC PSYCH	0	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	PROMOTION	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	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

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B-2 | Date/Time Prepared: 8/29/2012 9:24 am

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		BLOOD ADMINISTRATION	1	60.00	34,887	5.00
6.00		BLOOD ADMIN / OTHER OP SERVICES	1	30.00	-189,979	6.00
7.00		BLOOD ADMINISTRATION	1	91.00	-742	7.00
8.00		OTHER OUTPATIENT SERVICES	1	93.00	155,834	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,730,902		4,730,902	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,213,165		1,213,165	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,829,182		1,829,182	0	0	54.00
60.00	06000	LABORATORY	1,626,092		1,626,092	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	708,931	0	708,931	0	0	65.00
66.00	06600	PHYSICAL THERAPY	788,724	0	788,724	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	345,770		345,770	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	257,539		257,539	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,420		56,420	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	936,450		936,450	0	0	73.00
76.00	03020	GERIATRIC PSYCH	605,653		605,653	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,363,733		1,363,733	0	0	88.00
91.00	09100	EMERGENCY	2,346,705		2,346,705	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	262,791		262,791		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	155,834		155,834	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,099,273		1,099,273	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,327,164	0	18,327,164	0	0	200.00
201.00		Less Observation Beds	262,791		262,791		0	201.00
202.00		Total (see instructions)	18,064,373	0	18,064,373	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,670,974		2,670,974			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,575	2,724,802	2,732,377	0.443996	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,397,195	14,191,809	15,589,004	0.117338	0.000000	54.00
60.00	06000	LABORATORY	1,165,346	3,678,989	4,844,335	0.335669	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	480,426	281,251	761,677	0.930750	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	129,034	820,727	949,761	0.830445	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	538,076	1,287,632	1,825,708	0.189390	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,202	89,355	109,557	2.350731	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120,654	120,654	0.467618	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,486,587	1,290,576	2,777,163	0.337197	0.000000	73.00
76.00	03020	GERIATRIC PSYCH	0	761,040	761,040	0.795823	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	785,505	785,505			88.00
91.00	09100	EMERGENCY	71,171	4,032,457	4,103,628	0.571861	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,560	81,790	84,350	3.115483	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	490,307	490,307	0.317829	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	23,187	1,799,793	1,822,980	0.603009	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,992,333	32,436,687	40,429,020			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,992,333	32,436,687	40,429,020			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	GERIATRIC PSYCH	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
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 SERVICES	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/29/2012 9:24 am

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	4,730,902		4,730,902	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,213,165		1,213,165	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,829,182		1,829,182	0	0	54.00
60.00	06000	LABORATORY	1,626,092		1,626,092	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	708,931	0	708,931	0	0	65.00
66.00	06600	PHYSICAL THERAPY	788,724	0	788,724	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	345,770		345,770	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	257,539		257,539	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,420		56,420	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	936,450		936,450	0	0	73.00
76.00	03020	GERIATRIC PSYCH	605,653		605,653	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,363,733		1,363,733	0	0	88.00
91.00	09100	EMERGENCY	2,346,705		2,346,705	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	262,791		262,791		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	155,834		155,834	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,099,273		1,099,273	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	18,327,164	0	18,327,164	0	0	200.00
201.00		Less Observation Beds	262,791		262,791		0	201.00
202.00		Total (see instructions)	18,064,373	0	18,064,373	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/29/2012 9:24 am

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	2,670,974		2,670,974			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,575	2,724,802	2,732,377	0.443996	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,397,195	14,191,809	15,589,004	0.117338	0.000000	54.00
60.00	06000	LABORATORY	1,165,346	3,678,989	4,844,335	0.335669	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	480,426	281,251	761,677	0.930750	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	129,034	820,727	949,761	0.830445	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	538,076	1,287,632	1,825,708	0.189390	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,202	89,355	109,557	2.350731	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120,654	120,654	0.467618	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,486,587	1,290,576	2,777,163	0.337197	0.000000	73.00
76.00	03020	GERIATRIC PSYCH	0	761,040	761,040	0.795823	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	785,505	785,505	1.736123	0.000000	88.00
91.00	09100	EMERGENCY	71,171	4,032,457	4,103,628	0.571861	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,560	81,790	84,350	3.115483	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	490,307	490,307	0.317829	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	23,187	1,799,793	1,822,980	0.603009	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,992,333	32,436,687	40,429,020			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,992,333	32,436,687	40,429,020			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/29/2012 9:24 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	GERIATRIC PSYCH	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
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 SERVICES	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part II Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	268,212	2,732,377	0.098161	3,856	379	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	177,667	15,589,004	0.011397	800,285	9,121	54.00
60.00	06000	LABORATORY	78,505	4,844,335	0.016206	755,981	12,251	60.00
65.00	06500	RESPIRATORY THERAPY	66,609	761,677	0.087450	388,804	34,001	65.00
66.00	06600	PHYSICAL THERAPY	66,588	949,761	0.070110	26,759	1,876	66.00
69.00	06900	ELECTROCARDIOLOGY	76,607	1,825,708	0.041960	311,356	13,064	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,953	109,557	0.382933	15,885	6,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,439	120,654	0.011927	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,528	2,777,163	0.014233	971,843	13,832	73.00
76.00	03020	GERIATRIC PSYCH	51,209	761,040	0.067288	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	150,456	785,505	0.191540	0	0	88.00
91.00	09100	EMERGENCY	232,015	4,103,628	0.056539	556	31	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	84,350	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	490,307	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,250,788	35,935,066		3,275,325	90,638	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part IV | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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 SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part IV Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,732,377	0.000000	0.000000	3,856	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,589,004	0.000000	0.000000	800,285	54.00
60.00	06000	LABORATORY	0	4,844,335	0.000000	0.000000	755,981	60.00
65.00	06500	RESPIRATORY THERAPY	0	761,677	0.000000	0.000000	388,804	65.00
66.00	06600	PHYSICAL THERAPY	0	949,761	0.000000	0.000000	26,759	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,825,708	0.000000	0.000000	311,356	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	109,557	0.000000	0.000000	15,885	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	120,654	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,777,163	0.000000	0.000000	971,843	73.00
76.00	03020	GERIATRIC PSYCH	0	761,040	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	785,505	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	4,103,628	0.000000	0.000000	556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	84,350	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	490,307	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	35,935,066			3,275,325	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part IV | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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 SERVICES	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.443996	0	1,132,141	0		50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117338	0	4,687,426	0		54.00
60.00	06000	LABORATORY	0.335669	0	1,389,127	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.930750	0	169,322	0		65.00
66.00	06600	PHYSICAL THERAPY	0.830445	0	249,228	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0.189390	0	526,174	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.350731	0	51,465	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.467618	0	109,297	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.337197	0	881,254	0		73.00
76.00	03020	GERIATRIC PSYCH	0.795823	0	656,968	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
91.00	09100	EMERGENCY	0.571861	0	1,162,348	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.115483	0	39,370	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.317829	0	245,028	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.603009		0			95.00
200.00		Subtotal (see instructions)		0	11,299,148	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	11,299,148	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	502,666	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	550,013	0		54.00
60.00	06000	LABORATORY	0	466,287	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	157,596	0		65.00
66.00	06600	PHYSICAL THERAPY	0	206,970	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	99,652	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	120,980	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	51,109	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	297,156	0		73.00
76.00	03020	GERIATRIC PSYCH	0	522,830	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	664,701	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	122,657	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	77,877	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
200.00		Subtotal (see instructions)	0	3,840,494	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	3,840,494	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141323 | Component CCN: 14Z323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00	3.00	4.00		
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.443996	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117338	0	0	0		54.00
60.00	06000	LABORATORY	0.335669	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.930750	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.830445	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0.189390	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.350731	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.467618	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.337197	0	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0.795823	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
91.00	09100	EMERGENCY	0.571861	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.115483	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.317829	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.603009		0			95.00
200.00		Subtotal (see instructions)		0	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141323 | Component CCN: 14Z323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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 SERVICES	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
200.00		Subtotal (see instructions)	0	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-1 | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,261	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,782	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)	3,546	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	349	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)	116	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	11	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)	3	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,602	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)	327	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)	109	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	125.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	128.75	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,730,902	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)	1,375	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)	386	25.00
26.00	Total swing-bed cost (see instructions)	519,552	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,211,350	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,665,766	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,665,766	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.579790	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)	751.77	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,211,350	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)	1,113.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,897,405	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,897,405	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-1 | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,157,806	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,055,211	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)	364,124	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	121,375	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	485,499	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)	236	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,113.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	262,791	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-1 | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-3 | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,797,562		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.443996	3,856	1,712	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117338	800,285	93,904	54.00
60.00	06000	LABORATORY	0.335669	755,981	253,759	60.00
65.00	06500	RESPIRATORY THERAPY	0.930750	388,804	361,879	65.00
66.00	06600	PHYSICAL THERAPY	0.830445	26,759	22,222	66.00
69.00	06900	ELECTROCARDIOLOGY	0.189390	311,356	58,968	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.350731	15,885	37,341	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.467618	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.337197	971,843	327,703	73.00
76.00	03020	GERIATRIC PSYCH	0.795823	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.571861	556	318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.115483	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.317829	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,275,325	1,157,806	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)		3,275,325		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141323 | Component CCN: 14Z323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-3 | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		173,880		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.443996	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.117338	13,776	1,616	54.00
60.00	06000	LABORATORY	0.335669	59,242	19,886	60.00
65.00	06500	RESPIRATORY THERAPY	0.930750	28,344	26,381	65.00
66.00	06600	PHYSICAL THERAPY	0.830445	93,763	77,865	66.00
69.00	06900	ELECTROCARDIOLOGY	0.189390	3,100	587	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2.350731	900	2,116	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.467618	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.337197	123,865	41,767	73.00
76.00	03020	GERIATRIC PSYCH	0.795823	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.571861	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3.115483	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.317829	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		322,990	170,218	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)		322,990		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141323	Period: From 04/01/2011 To 03/31/2012	Worksheet E Part B Date/Time Prepared: 8/29/2012 9:24 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,840,494	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)	3,840,494	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)	3,878,899	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)	22,771	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,964,239	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)	1,891,889	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)	1,891,889	30.00
31.00	Primary payer payments	372	31.00
32.00	Subtotal (line 30 minus line 31)	1,891,517	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,891,517	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)	1,891,517	40.00
41.00	Interim payments	1,724,950	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)	166,567	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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 8/29/2012 9:24 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,898,173		1,677,059	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	09/30/2011	112,490	09/30/2011	47,891	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		112,490		47,891	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,010,663		1,724,950	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		398,382		166,567	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,409,045		1,891,517	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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 8/29/2012 9:24 am

Component CCN: 14Z323 | 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		577,455		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	09/30/2011	26,533		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		26,533		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)		603,988		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		53,430		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		657,418		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: 141323 Component CCN: 14Z323	Period: From 04/01/2011 To 03/31/2012	Worksheet E-2 Date/Time Prepared: 8/29/2012 9:24 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	490,354	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)	171,920	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	436	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)	662,274	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	662,274	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)	662,274	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,856	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)	657,418	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)	657,418	0	19.00
20.00	Interim payments	603,988	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)	53,430	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: 141323	Period: From 04/01/2011 To 03/31/2012	Worksheet E-3 Part V Date/Time Prepared: 8/29/2012 9:24 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	4,055,211	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)	4,055,211	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,095,763	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)	4,095,763	19.00
20.00	Deductibles (exclude professional component)	462,486	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	3,633,277	22.00
23.00	Coinsurance	5,094	23.00
24.00	Subtotal (line 22 minus line 23)	3,628,183	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	780,862	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	780,862	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,409,045	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	4,409,045	30.00
31.00	Interim payments	4,010,663	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)	398,382	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: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet G | Date/Time Prepared: 8/29/2012 9:24 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	8,254,661	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,154,097	0	0	0	4.00
5.00	Other receivable	233,318	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,394,000	0	0	0	6.00
7.00	Inventory	337,383	0	0	0	7.00
8.00	Prepaid expenses	395,661	0	0	0	8.00
9.00	Other current assets	883,359	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,864,479	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	13,980	0	0	0	12.00
13.00	Land improvements	1,055,937	0	0	0	13.00
14.00	Accumulated depreciation	-258,184	0	0	0	14.00
15.00	Buildings	19,230,502	0	0	0	15.00
16.00	Accumulated depreciation	-5,714,613	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,084,531	0	0	0	23.00
24.00	Accumulated depreciation	-5,202,057	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)	16,210,096	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,009,644	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	327,070	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,336,714	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,411,289	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,756,403	0	0	0	37.00
38.00	Salaries, wages, and fees payable	746,948	0	0	0	38.00
39.00	Payroll taxes payable	458,804	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,102,992	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	205,899	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,271,046	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,645,002	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	11,645,002	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	15,916,048	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	14,495,241				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	14,495,241	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,411,289	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet G-1 | Date/Time Prepared: 8/29/2012 9:24 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		13,675,569		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		819,672				2.00
3.00	Total (sum of line 1 and line 2)		14,495,241		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		14,495,241		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)		14,495,241		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet G-1 | Date/Time Prepared: 8/29/2012 9:24 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet G-2 Parts | Date/Time Prepared: 8/29/2012 9:24 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,665,766		2,665,766	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	191,370		191,370	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,857,136		2,857,136	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,857,136		2,857,136	17.00
18.00	Ancillary services	5,291,079	30,862,421	36,153,500	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	785,505	785,505	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	23,187	1,799,793	1,822,980	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,171,402	33,447,719	41,619,121	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,399,790		29.00
30.00	BAD DEBT EXPENSE	3,221,301			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		3,221,301		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)		22,621,091		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141323	Period: From 04/01/2011 To 03/31/2012	Worksheet G-3 Date/Time Prepared: 8/29/2012 9:24 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	41,619,121	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,713,907	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,905,214	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,621,091	4.00
5.00	Net income from service to patients (line 3 minus line 4)	284,123	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	156,101	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	8,590	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	72,930	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	1,092	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	105,443	22.00
23.00	Governmental appropriations	188,584	23.00
24.00	GRANTS AND GIFTS	28,539	24.00
24.02	OTHER MISCELLANEOUS INCOME	4,002	24.02
25.00	Total other income (sum of lines 6-24)	565,281	25.00
26.00	Total (line 5 plus line 25)	849,404	26.00
27.00	SURG PROFESSIONAL SALARIES	29,732	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	29,732	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	819,672	29.00

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

Provider CCN: 141323 Component CCN: 143478 | Period: From 04/01/2011 To 03/31/2012 | Worksheet M-1 | Date/Time Prepared: 8/29/2012 9:24 am

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	166,070	0	166,070	0	166,070	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	310,250	0	310,250	0	310,250	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	476,320	0	476,320	0	476,320	10.00
11.00	Physician Services Under Agreement	0	141,112	141,112	0	141,112	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	86,319	86,319	0	86,319	13.00
14.00	Subtotal (sum of lines 11-13)	0	227,431	227,431	0	227,431	14.00
15.00	Medical Supplies	0	21,839	21,839	0	21,839	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	21,839	21,839	0	21,839	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	476,320	249,270	725,590	0	725,590	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	1,085	1,085	44,133	45,218	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,085	1,085	44,133	45,218	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	476,320	250,355	726,675	44,133	770,808	32.00

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

Provider CCN: 141323 | Component CCN: 143478 | Period: From 04/01/2011 To 03/31/2012 | Worksheet M-1 | Date/Time Prepared: 8/29/2012 9:24 am

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

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	166,070		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	310,250		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	476,320		10.00
11.00	Physician Services Under Agreement	0	141,112		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	86,319		13.00
14.00	Subtotal (sum of lines 11-13)	0	227,431		14.00
15.00	Medical Supplies	0	21,839		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	21,839		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	725,590		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	45,218		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	45,218		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	770,808		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141323 | Period: From 04/01/2011 To 03/31/2012 | Worksheet M-2

Component CCN: 143478 | Date/Time Prepared: 8/29/2012 9:24 am

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.60	3,649	4,200	2,520		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.00	6,066	2,100	4,200		3.00
4.00	Subtotal (sum of lines 1-3)	2.60	9,715		6,720	9,715	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)	2.60	9,715			9,715	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)					725,590	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)					725,590	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)					45,218	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					592,925	15.00
16.00	Total overhead (sum of lines 14 and 15)					638,143	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					638,143	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					638,143	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,363,733	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141323 Component CCN: 143478	Period: From 04/01/2011 To 03/31/2012	Worksheet M-3 Date/Time Prepared: 8/29/2012 9:24 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,363,733	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		4,576	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,359,157	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		9,715	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)		9,715	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		139.90	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)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	139.90	139.90	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,218	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	170,398	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	170,398	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		129,995	16.04
16.05	Total program cost (see instructions)		129,995	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,904	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		129,995	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		129,995	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		129,995	26.00
27.00	Interim payments		138,624	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)		-8,629	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: 141323 Component CCN: 143478	Period: From 04/01/2011 To 03/31/2012	Worksheet M-4 Date/Time Prepared: 8/29/2012 9:24 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	476,320	476,320	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000492	0.000051	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	234	24	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,110	67	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,344	91	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	725,590	725,590	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	638,143	638,143	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003230	0.000125	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,061	80	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,405	171	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	67	7	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	65.75	24.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	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)		4,576	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)		0	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141323 Component CCN: 143478	Period: From 04/01/2011 To 03/31/2012	Worksheet M-5 Date/Time Prepared: 8/29/2012 9:24 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		146,038	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		09/30/2011	7,414	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)		-7,414	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		138,624	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		8,629	6.02
7.00	Total Medicare program liability (see instructions)		129,995	7.00

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