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: 141324	Period: From 04/01/2011 To 03/31/2012	Worksheet S Parts I-III Date/Time Prepared: 8/28/2012 4:20 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/28/2012 Time: 4:20 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 FERRELL 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	359,327	-235,083	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	19,678	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		-18,311		0	10.00
10.01	RURAL HEALTH CLINIC II II	0		-24,698		0	10.01
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	379,005	-278,092	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 8/28/2012 4:19 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1201 PINE STREET	PO Box:			1.00
2.00	City: EL DORADO	State: IL	Zip Code: 62930-	County: SALINE	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	FERRELL HOSPITAL	141324	14999	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	FERRELL S/B SNF	14Z324	14999		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	ELDORADO	148507	14999		04/01/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1	FERRELL CLINIC	148506	14999		12/01/2010	N	O	N	15.01
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: 1.00	To: 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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		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.	2	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 1.00	Date of Geogr 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: 1.00	Ending: 2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00

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

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

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		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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	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.	N		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.	0		118.00

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		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.	0	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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 8/28/2012 4:19 pm

		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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 8/28/2012 4:19 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	07/31/2012	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	07/13/2012		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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 8/28/2012 4:19 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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.	JAKE	CARNAZZO	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923476	JCARNAZZO@ALLIANTMANAGEMENT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 8/28/2012 4:19 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	07/13/2012	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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-3 Part I Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	70,512.00		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	70,512.00		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	70,512.00		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
26.01	RURAL HEALTH CLINIC II	88.01					26.01
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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,980	383	2,938		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	251	0	251		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		37	37		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,231	420	3,226		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0	2,231	420	3,226		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						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	690	0	3,993		26.00
26.01	RURAL HEALTH CLINIC II	0	3,152	0	11,379		26.01
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	638		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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	554	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	161.44	0.00	0	554	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	1.40	0.00			26.00
26.01	RURAL HEALTH CLINIC II	0.00	2.75	0.00			26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	165.59	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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	139	875		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)	139	875		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
26.01	RURAL HEALTH CLINIC II				26.01
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: 141324 Component CCN: 148507 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-8 | Date/Time Prepared: 8/28/2012 4:19 pm

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			1201 PINE STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	EL DORADO		IL	62930	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			07:30	16:00	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.			Y	2	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	Provider name, CCN number		EL DORADO		148507	14.00
14.01						14.01
14.02						14.02
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)	N	0	0	0	15.00

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

Provider CCN: 141324
Component CCN: 148507

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

Worksheet S-8

Date/Time Prepared:
8/28/2012 4:19 pm

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		SALINE				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	16:00	07:00	19:00		11.00

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

Provider CCN: 141324
Component CCN: 148507

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

Worksheet S-8

Date/Time Prepared:
8/28/2012 4:19 pm

Rural Health Clinic (RHC) I

Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30	07:30	11:30		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141324 Component CCN: 148507	Period: From 04/01/2011 To 03/31/2012	Worksheet S-8 Date/Time Prepared: 8/28/2012 4:19 pm
		Rural Health Clinic (RHC) I	Cost

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

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

Provider CCN: 141324 Component CCN: 148506 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-8 | Date/Time Prepared: 8/28/2012 4:19 pm

				Rural Health Clinic (RHC) II	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			1201 PINE STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	EL DORADO		IL	62930	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			07:30	16:00	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.			Y	2	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	Provider name, CCN number		FERRELL CLINIC		148506	14.00
14.01						14.01
14.02						14.02
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)	N	0	0	0	15.00

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

Provider CCN: 141324
Component CCN: 148506

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

Worksheet S-8

Date/Time Prepared:
8/28/2012 4:19 pm

Rural Health Clinic (RHC) II

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		SALINE				2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	16:00	07:00	19:00		11.00

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

Provider CCN: 141324
Component CCN: 148506

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

Worksheet S-8

Date/Time Prepared:
8/28/2012 4:19 pm

Rural Health Clinic (RHC) II

Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30	07:30	11:30		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141324 Component CCN: 148506	Period: From 04/01/2011 To 03/31/2012	Worksheet S-8 Date/Time Prepared: 8/28/2012 4:19 pm
		Rural Health Clinic (RHC) II	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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet S-10 | Date/Time Prepared: 8/28/2012 4:19 pm

		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)	0.445714	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,071,543	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	6,388,185	6.00
7.00	Medicaid cost (line 1 times line 6)	2,847,303	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)	775,760	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)	775,760	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	993,335	46,164	1,039,499	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	442,743	20,576	463,319	21.00
22.00	Partial payment by patients approved for charity care	962	30,560	31,522	22.00
23.00	Cost of charity care (line 21 minus line 22)	441,781	-9,984	431,797	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,462,950	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	534,781	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	928,169	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	413,698	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	845,495	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,621,255	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT		817,307	817,307	0	817,307	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,273	1,273	2.00
4.00	EMPLOYEE BENEFITS	68,355	1,994,147	2,062,502	0	2,062,502	4.00
5.00	ADMINISTRATIVE & GENERAL	699,523	1,768,951	2,468,474	-59,041	2,409,433	5.00
6.00	MAINTENANCE & REPAIRS	178,585	73,907	252,492	0	252,492	6.00
7.00	OPERATION OF PLANT	0	156,138	156,138	62,992	219,130	7.00
8.00	LAUNDRY & LINEN SERVICE	42,151	8,682	50,833	0	50,833	8.00
9.00	HOUSEKEEPING	158,200	13,854	172,054	0	172,054	9.00
10.00	DIETARY	186,470	163,018	349,488	-93,734	255,754	10.00
11.00	CAFETERIA	0	0	0	93,734	93,734	11.00
13.00	NURSING ADMINISTRATION	186,428	10,864	197,292	0	197,292	13.00
16.00	MEDICAL RECORDS & LIBRARY	189,007	23,517	212,524	0	212,524	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,135,508	61,049	1,196,557	-971	1,195,586	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	216,102	62,086	278,188	-416	277,772	50.00
53.00	ANESTHESIOLOGY	64,058	148,256	212,314	0	212,314	53.00
54.00	RADIOLOGY-DIAGNOSTIC	417,360	635,167	1,052,527	0	1,052,527	54.00
60.00	LABORATORY	404,394	547,095	951,489	0	951,489	60.00
65.00	RESPIRATORY THERAPY	316,134	105,786	421,920	0	421,920	65.00
66.00	PHYSICAL THERAPY	225,137	46,405	271,542	-1,594	269,948	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	94,281	177,703	271,984	-4,593	267,391	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	5,031	5,031	72.00
73.00	DRUGS CHARGED TO PATIENTS	210,477	573,346	783,823	-33	783,790	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	236,169	43,535	279,704	43,031	322,735	88.00
88.01	RURAL HEALTH CLINIC II	614,035	211,302	825,337	8,922	834,259	88.01
90.00	CLINIC	330,318	174,265	504,583	-1,376	503,207	90.00
91.00	EMERGENCY	485,577	741,273	1,226,850	-51,857	1,174,993	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,458,269	8,557,653	15,015,922	1,368	15,017,290	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	767,935	177,775	945,710	-178	945,532	192.00
192.01	MARKETING	94,990	156,547	251,537	-1,190	250,347	192.01
200.00	TOTAL (SUM OF LINES 118-199)	7,321,194	8,891,975	16,213,169	0	16,213,169	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-9,643	807,664		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,273		2.00
4.00	EMPLOYEE BENEFITS	0	2,062,502		4.00
5.00	ADMINISTRATIVE & GENERAL	-38,555	2,370,878		5.00
6.00	MAINTENANCE & REPAIRS	0	252,492		6.00
7.00	OPERATION OF PLANT	-26,575	192,555		7.00
8.00	LAUNDRY & LINEN SERVICE	0	50,833		8.00
9.00	HOUSEKEEPING	0	172,054		9.00
10.00	DIETARY	0	255,754		10.00
11.00	CAFETERIA	-31,840	61,894		11.00
13.00	NURSING ADMINISTRATION	0	197,292		13.00
16.00	MEDICAL RECORDS & LIBRARY	-10,702	201,822		16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,195,586		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	277,772		50.00
53.00	ANESTHESIOLOGY	-952	211,362		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,052,527		54.00
60.00	LABORATORY	0	951,489		60.00
65.00	RESPIRATORY THERAPY	0	421,920		65.00
66.00	PHYSICAL THERAPY	0	269,948		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	267,391		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	5,031		72.00
73.00	DRUGS CHARGED TO PATIENTS	-28,239	755,551		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	322,735		88.00
88.01	RURAL HEALTH CLINIC II	0	834,259		88.01
90.00	CLINIC	0	503,207		90.00
91.00	EMERGENCY	-364,375	810,618		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-510,881	14,506,409		118.00
	NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	945,532		192.00
192.01	MARKETING	0	250,347		192.01
200.00	TOTAL (SUM OF LINES 118-199)	-510,881	15,702,288		200.00

RECLASSIFICATIONS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-6 | Date/Time Prepared: 8/28/2012 4:19 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	50,012	43,722		1.00
	TOTALS		50,012	43,722		
	B - RENT					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,273		1.00
3.00		0.00	0	0		3.00
6.00		0.00	0	0		6.00
9.00		0.00	0	0		9.00
	TOTALS		0	1,273		
	D - UTLITIES					
1.00	OPERATION OF PLANT	7.00	0	62,992		1.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
6.00	RURAL HEALTH CLINIC	88.00	0	85		6.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	TOTALS		0	63,077		
	E - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	322		1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	5,031		2.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
10.00	RURAL HEALTH CLINIC II	88.01	0	11		10.00
	TOTALS		0	5,364		
	G - RHC SALARY					
1.00	RURAL HEALTH CLINIC	88.00	42,946	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	8,911	0		2.00
	TOTALS		51,857	0		
500.00	Grand Total: Increases		101,869	113,436		500.00

RECLASSIFICATIONS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-6 | Date/Time Prepared: 8/28/2012 4:19 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	50,012	43,722	0	1.00
	TOTALS		50,012	43,722		
	B - RENT					
1.00		0.00	0	0	9	1.00
3.00	ADULTS & PEDIATRICS	30.00	0	971	0	3.00
6.00	CLINIC	90.00	0	299	0	6.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3	0	9.00
	TOTALS		0	1,273		
	D - UTLITIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	59,041	0	1.00
3.00	PHYSICAL THERAPY	66.00	0	1,594	0	3.00
4.00	CLINIC	90.00	0	1,077	0	4.00
6.00		0.00	0	0	0	6.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	175	0	8.00
9.00	MARKETING	192.01	0	1,190	0	9.00
	TOTALS		0	63,077		
	E - MED SUPPLY					
1.00		0.00	0	0	0	1.00
2.00	OPERATING ROOM	50.00	416	0	0	2.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	4,915	0	0	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	33	0	0	8.00
10.00		0.00	0	0	0	10.00
	TOTALS		5,364	0		
	G - RHC SALARY					
1.00	EMERGENCY	91.00	51,857	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		51,857	0		
500.00	Grand Total: Decreases		107,233	108,072		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 8/28/2012 4:19 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	159,712	0	0	0	0	1.00
2.00	Land Improvements	44,285	0	0	0	0	2.00
3.00	Buildings and Fixtures	2,796,293	595,136	0	595,136	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,609,581	133,723	0	133,723	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5,609,871	728,859	0	728,859	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	5,609,871	728,859	0	728,859	0	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	817,307	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	817,307	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	817,307	0	817,307	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	817,307	0	817,307	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 8/28/2012 4:19 pm

		Ending Balance	Fully Depreciated Assets		
		6.00	7.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES				
1.00	Land	159,712	0		1.00
2.00	Land Improvements	44,285	0		2.00
3.00	Buildings and Fixtures	3,391,429	0		3.00
4.00	Building Improvements	0	0		4.00
5.00	Fixed Equipment	2,743,304	0		5.00
6.00	Movable Equipment	0	0		6.00
7.00	HIT designated Assets	0	0		7.00
8.00	Subtotal (sum of lines 1-7)	6,338,730	0		8.00
9.00	Reconciling Items	0	0		9.00
10.00	Total (line 8 minus line 9)	6,338,730	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	817,307		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	817,307		3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	817,307	-9,643	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,273	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	818,580	-9,643	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	807,664	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,273	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	808,937	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8 | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-9,643	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-1,285	ADMINISTRATIVE & GENERAL	5.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		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	-365,327			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-146	ADMINISTRATIVE & GENERAL	5.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-27,697	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others	B	-26,575	OPERATION OF PLANT	7.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients	B	-28,239	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00	Sale of medical records and abstracts	B	-10,702	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines	B	-4,143	CAFETERIA	11.00	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
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	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	33.00
34.00	MISC INCOME	B	-17,467	ADMINISTRATIVE & GENERAL	5.00	34.00
35.00	PROVIDER TAX	A	-1	ADMINISTRATIVE & GENERAL	5.00	35.00
36.00	COST REPORT PAYBACK INTEREST	A	-19,656	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00			0		0.00	37.00
38.00			0		0.00	38.00
39.00			0		0.00	39.00
40.00			0		0.00	40.00
41.00			0		0.00	41.00
42.00			0		0.00	42.00
43.00			0		0.00	43.00
44.00			0		0.00	44.00
45.00			0		0.00	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-510,881			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8 | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00					
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	10					1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0					2.00
3.00	Investment income - other (chapter 2)	0					3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0					4.00
5.00	Refunds and rebates of expenses (chapter 8)	0					5.00
6.00	Rental of provider space by suppliers (chapter 8)	0					6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0					7.00
8.00	Television and radio service (chapter 21)	0					8.00
9.00	Parking lot (chapter 21)	0					9.00
10.00	Provider-based physician adjustment	0					10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0					11.00
12.00	Related organization transactions (chapter 10)	0					12.00
13.00	Laundry and linen service	0					13.00
14.00	Cafeteria-employees and guests	0					14.00
15.00	Rental of quarters to employee and others	0					15.00
16.00	Sale of medical and surgical supplies to other than patients	0					16.00
17.00	Sale of drugs to other than patients	0					17.00
18.00	Sale of medical records and abstracts	0					18.00
19.00	Nursing school (tuition, fees, books, etc.)	0					19.00
20.00	Vending machines	0					20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0					21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0					22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)						23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)						24.00
25.00	Utilization review - physicians' compensation (chapter 21)						25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0					26.00
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	OTHER ADJUSTMENTS (SPECIFY) (3)	0					33.00
34.00	MISC INCOME	0					34.00
35.00	PROVIDER TAX	0					35.00
36.00	COST REPORT PAYBACK INTEREST	0					36.00
37.00		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		0					42.00
43.00		0					43.00
44.00		0					44.00
45.00		0					45.00
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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 8/28/2012 4:19 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	717,947	364,375	1.00
2.00		53.00	ANESTHESIOLOGY	952	952	2.00
3.00		0.00		0	0	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				718,899	365,327	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 8/28/2012 4:19 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		353,572	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		353,572		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 8/28/2012 4:19 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 8/28/2012 4:19 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	364,375		1.00
2.00		0	952		2.00
3.00		0	0		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	365,327		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part I Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	807,664	807,664				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,273		1,273			2.00
4.00	EMPLOYEE BENEFITS	2,062,502	0	0	2,062,502		4.00
5.00	ADMINISTRATIVE & GENERAL	2,370,878	247,695	392	199,072	2,818,037	5.00
6.00	MAINTENANCE & REPAIRS	252,492	30,731	48	50,822	334,093	6.00
7.00	OPERATION OF PLANT	192,555	38,550	61	0	231,166	7.00
8.00	LAUNDRY & LINEN SERVICE	50,833	24,268	38	11,995	87,134	8.00
9.00	HOUSEKEEPING	172,054	10,426	16	45,021	227,517	9.00
10.00	DIETARY	255,754	37,018	58	38,833	331,663	10.00
11.00	CAFETERIA	61,894	5,759	9	14,233	81,895	11.00
13.00	NURSING ADMINISTRATION	197,292	18,544	29	53,054	268,919	13.00
16.00	MEDICAL RECORDS & LIBRARY	201,822	9,404	15	53,788	265,029	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,195,586	138,244	218	323,147	1,657,195	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	277,772	22,771	36	61,380	361,959	50.00
53.00	ANESTHESIOLOGY	211,362	4,403	7	18,230	234,002	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,052,527	36,331	57	118,773	1,207,688	54.00
60.00	LABORATORY	951,489	18,667	29	115,083	1,085,268	60.00
65.00	RESPIRATORY THERAPY	421,920	35,028	55	89,966	546,969	65.00
66.00	PHYSICAL THERAPY	269,948	2,113	3	64,070	336,134	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	267,391	6,234	10	25,432	299,067	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	5,031	0	0	0	5,031	72.00
73.00	DRUGS CHARGED TO PATIENTS	755,551	21,467	34	59,889	836,941	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	322,735	0	0	79,431	402,166	88.00
88.01	RURAL HEALTH CLINIC II	834,259	49,204	78	177,279	1,060,820	88.01
90.00	CLINIC	503,207	27,983	44	94,003	625,237	90.00
91.00	EMERGENCY	810,618	6,974	11	123,429	941,032	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,506,409	791,814	1,248	1,816,930	14,244,962	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	945,532	15,850	25	218,540	1,179,947	192.00
192.01	MARKETING	250,347	0	0	27,032	277,379	192.01
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	15,702,288	807,664	1,273	2,062,502	15,702,288	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part I Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	2,818,037					5.00
6.00	MAINTENANCE & REPAIRS	73,073	407,166				6.00
7.00	OPERATION OF PLANT	50,561	29,658	311,385			7.00
8.00	LAUNDRY & LINEN SERVICE	19,058	18,670	15,400	140,262		8.00
9.00	HOUSEKEEPING	49,763	8,021	6,616	0	291,917	9.00
10.00	DIETARY	72,541	28,479	23,491	0	23,698	10.00
11.00	CAFETERIA	17,912	4,430	3,654	0	3,687	11.00
13.00	NURSING ADMINISTRATION	58,818	14,267	11,768	0	11,871	13.00
16.00	MEDICAL RECORDS & LIBRARY	57,967	7,235	5,968	0	6,020	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	362,453	106,359	87,728	140,262	88,503	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	79,168	17,518	14,450	0	14,577	50.00
53.00	ANESTHESIOLOGY	51,181	3,387	2,794	0	2,818	53.00
54.00	RADIOLOGY-DIAGNOSTIC	264,146	27,951	23,055	0	23,258	54.00
60.00	LABORATORY	237,370	14,362	11,846	0	11,950	60.00
65.00	RESPIRATORY THERAPY	119,633	26,948	22,228	0	22,424	65.00
66.00	PHYSICAL THERAPY	73,519	1,626	1,341	0	1,353	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,412	4,796	3,956	0	3,991	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,100	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	183,056	16,516	13,623	0	13,743	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	87,962	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	232,023	37,855	31,225	0	31,499	88.01
90.00	CLINIC	136,752	21,529	17,758	0	17,914	90.00
91.00	EMERGENCY	205,823	5,365	4,426	0	4,464	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,499,291	394,972	301,327	140,262	281,770	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	258,078	12,194	10,058	0	10,147	192.00
192.01	MARKETING	60,668	0	0	0	0	192.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,818,037	407,166	311,385	140,262	291,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part I Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		10.00	11.00	13.00	16.00	19.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	479,872					10.00
11.00	CAFETERIA	0	111,578				11.00
13.00	NURSING ADMINISTRATION	0	2,668	368,311			13.00
16.00	MEDICAL RECORDS & LIBRARY	0	5,911	0	348,130		16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	479,872	25,554	256,935	38,885	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	3,882	39,026	17,094	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	8,125	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,168	0	82,494	0	54.00
60.00	LABORATORY	0	10,829	0	66,871	0	60.00
65.00	RESPIRATORY THERAPY	0	7,368	0	21,253	0	65.00
66.00	PHYSICAL THERAPY	0	4,127	0	10,465	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,992	0	14,829	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	584	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,718	0	30,820	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	16,799	0	16,414	0	88.01
90.00	CLINIC	0	6,784	0	15,844	0	90.00
91.00	EMERGENCY	0	7,196	72,350	24,452	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	479,872	105,996	368,311	348,130	0	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,715	0	0	0	192.00
192.01	MARKETING	0	1,867	0	0	0	192.01
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	479,872	111,578	368,311	348,130	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part I Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
19.00	NONPHYSICIAN ANESTHETISTS					19.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	3,243,746	0	3,243,746		30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	547,674	0	547,674		50.00
53.00	ANESTHESIOLOGY	302,307	0	302,307		53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,636,760	0	1,636,760		54.00
60.00	LABORATORY	1,438,496	0	1,438,496		60.00
65.00	RESPIRATORY THERAPY	766,823	0	766,823		65.00
66.00	PHYSICAL THERAPY	428,565	0	428,565		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	395,043	0	395,043		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	6,715	0	6,715		72.00
73.00	DRUGS CHARGED TO PATIENTS	1,098,417	0	1,098,417		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	490,128	0	490,128		88.00
88.01	RURAL HEALTH CLINIC II	1,426,635	0	1,426,635		88.01
90.00	CLINIC	841,818	0	841,818		90.00
91.00	EMERGENCY	1,265,108	0	1,265,108		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,888,235	0	13,888,235		118.00
	NONREIMBURSABLE COST CENTERS					
192.00	PHYSICIANS' PRIVATE OFFICES	1,474,139	0	1,474,139		192.00
192.01	MARKETING	339,914	0	339,914		192.01
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	15,702,288	0	15,702,288		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part II Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	247,695	392	248,087	0	5.00
6.00	MAINTENANCE & REPAIRS	0	30,731	48	30,779	0	6.00
7.00	OPERATION OF PLANT	0	38,550	61	38,611	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	24,268	38	24,306	0	8.00
9.00	HOUSEKEEPING	0	10,426	16	10,442	0	9.00
10.00	DIETARY	0	37,018	58	37,076	0	10.00
11.00	CAFETERIA	0	5,759	9	5,768	0	11.00
13.00	NURSING ADMINISTRATION	0	18,544	29	18,573	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	9,404	15	9,419	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	138,244	218	138,462	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	22,771	36	22,807	0	50.00
53.00	ANESTHESIOLOGY	0	4,403	7	4,410	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	36,331	57	36,388	0	54.00
60.00	LABORATORY	0	18,667	29	18,696	0	60.00
65.00	RESPIRATORY THERAPY	0	35,028	55	35,083	0	65.00
66.00	PHYSICAL THERAPY	0	2,113	3	2,116	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,234	10	6,244	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	21,467	34	21,501	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	49,204	78	49,282	0	88.01
90.00	CLINIC	0	27,983	44	28,027	0	90.00
91.00	EMERGENCY	0	6,974	11	6,985	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	791,814	1,248	793,062	0	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	15,850	25	15,875	0	192.00
192.01	MARKETING	0	0	0	0	0	192.01
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	807,664	1,273	808,937	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part II Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	248,087					5.00
6.00	MAINTENANCE & REPAIRS	6,433	37,212				6.00
7.00	OPERATION OF PLANT	4,451	2,711	45,773			7.00
8.00	LAUNDRY & LINEN SERVICE	1,678	1,706	2,264	29,954		8.00
9.00	HOUSEKEEPING	4,381	733	973	0	16,529	9.00
10.00	DIETARY	6,386	2,603	3,453	0	1,342	10.00
11.00	CAFETERIA	1,577	405	537	0	209	11.00
13.00	NURSING ADMINISTRATION	5,178	1,304	1,730	0	672	13.00
16.00	MEDICAL RECORDS & LIBRARY	5,103	661	877	0	341	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	31,908	9,719	12,894	29,954	5,009	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,970	1,601	2,124	0	825	50.00
53.00	ANESTHESIOLOGY	4,506	310	411	0	160	53.00
54.00	RADIOLOGY-DIAGNOSTIC	23,254	2,555	3,389	0	1,317	54.00
60.00	LABORATORY	20,897	1,313	1,741	0	677	60.00
65.00	RESPIRATORY THERAPY	10,532	2,463	3,268	0	1,270	65.00
66.00	PHYSICAL THERAPY	6,472	149	197	0	77	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,759	438	582	0	226	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	97	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	16,115	1,509	2,003	0	778	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	7,744	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	20,426	3,460	4,590	0	1,784	88.01
90.00	CLINIC	12,039	1,968	2,610	0	1,014	90.00
91.00	EMERGENCY	18,120	490	651	0	253	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	220,026	36,098	44,294	29,954	15,954	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	22,720	1,114	1,479	0	575	192.00
192.01	MARKETING	5,341	0	0	0	0	192.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	248,087	37,212	45,773	29,954	16,529	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part II Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		10.00	11.00	13.00	16.00	19.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	50,860					10.00
11.00	CAFETERIA	0	8,496				11.00
13.00	NURSING ADMINISTRATION	0	203	27,660			13.00
16.00	MEDICAL RECORDS & LIBRARY	0	450	0	16,851		16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	50,860	1,945	19,296	1,881		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	296	2,931	827		50.00
53.00	ANESTHESIOLOGY	0	0	0	393		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	622	0	4,002		54.00
60.00	LABORATORY	0	825	0	3,235		60.00
65.00	RESPIRATORY THERAPY	0	561	0	1,028		65.00
66.00	PHYSICAL THERAPY	0	314	0	506		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	228	0	717		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	28		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	283	0	1,491		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	1,279	0	794		88.01
90.00	CLINIC	0	517	0	766		90.00
91.00	EMERGENCY	0	548	5,433	1,183		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	50,860	8,071	27,660	16,851	0	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	283	0	0		192.00
192.01	MARKETING	0	142	0	0		192.01
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	50,860	8,496	27,660	16,851	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B Part II | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
19.00	NONPHYSICIAN ANESTHETISTS					19.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	301,928	0	301,928		30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	38,381	0	38,381		50.00
53.00	ANESTHESIOLOGY	10,190	0	10,190		53.00
54.00	RADIOLOGY-DIAGNOSTIC	71,527	0	71,527		54.00
60.00	LABORATORY	47,384	0	47,384		60.00
65.00	RESPIRATORY THERAPY	54,205	0	54,205		65.00
66.00	PHYSICAL THERAPY	9,831	0	9,831		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,194	0	14,194		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	125	0	125		72.00
73.00	DRUGS CHARGED TO PATIENTS	43,680	0	43,680		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	7,744	0	7,744		88.00
88.01	RURAL HEALTH CLINIC II	81,615	0	81,615		88.01
90.00	CLINIC	46,941	0	46,941		90.00
91.00	EMERGENCY	33,663	0	33,663		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
	SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	761,408	0	761,408		118.00
	NONREIMBURSABLE COST CENTERS					
192.00	PHYSICIANS' PRIVATE OFFICES	42,046	0	42,046		192.00
192.01	MARKETING	5,483	0	5,483		192.01
200.00	Cross Foot Adjustments	0	0	0		200.00
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	808,937	0	808,937		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B-1 | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	45,862					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		45,862				2.00
4.00	EMPLOYEE BENEFITS	0	0	7,247,475			4.00
5.00	ADMINISTRATIVE & GENERAL	14,065	14,065	699,523	-2,818,037	12,884,251	5.00
6.00	MAINTENANCE & REPAIRS	1,745	1,745	178,585	0	334,093	6.00
7.00	OPERATION OF PLANT	2,189	2,189	0	0	231,166	7.00
8.00	LAUNDRY & LINEN SERVICE	1,378	1,378	42,151	0	87,134	8.00
9.00	HOUSEKEEPING	592	592	158,200	0	227,517	9.00
10.00	DIETARY	2,102	2,102	136,458	0	331,663	10.00
11.00	CAFETERIA	327	327	50,012	0	81,895	11.00
13.00	NURSING ADMINISTRATION	1,053	1,053	186,428	0	268,919	13.00
16.00	MEDICAL RECORDS & LIBRARY	534	534	189,007	0	265,029	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,850	7,850	1,135,508	0	1,657,195	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,293	1,293	215,686	0	361,959	50.00
53.00	ANESTHESIOLOGY	250	250	64,058	0	234,002	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,063	2,063	417,360	0	1,207,688	54.00
60.00	LABORATORY	1,060	1,060	404,394	0	1,085,268	60.00
65.00	RESPIRATORY THERAPY	1,989	1,989	316,134	0	546,969	65.00
66.00	PHYSICAL THERAPY	120	120	225,137	0	336,134	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	354	354	89,366	0	299,067	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5,031	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,219	1,219	210,444	0	836,941	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	279,115	0	402,166	88.00
88.01	RURAL HEALTH CLINIC II	2,794	2,794	622,946	0	1,060,820	88.01
90.00	CLINIC	1,589	1,589	330,318	0	625,237	90.00
91.00	EMERGENCY	396	396	433,720	0	941,032	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	44,962	44,962	6,384,550	-2,818,037	11,426,925	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	900	900	767,935	0	1,179,947	192.00
192.01	MARKETING	0	0	94,990	0	277,379	192.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	807,664	1,273	2,062,502		2,818,037	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.610745	0.027757	0.284582		0.218720	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		248,087	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.019255	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B-1 | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	30,052					6.00
7.00	OPERATION OF PLANT	2,189	27,863				7.00
8.00	LAUNDRY & LINEN SERVICE	1,378	1,378	100			8.00
9.00	HOUSEKEEPING	592	592	0	25,893		9.00
10.00	DIETARY	2,102	2,102	0	2,102	100	10.00
11.00	CAFETERIA	327	327	0	327	0	11.00
13.00	NURSING ADMINISTRATION	1,053	1,053	0	1,053	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	534	534	0	534	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,850	7,850	100	7,850	100	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,293	1,293	0	1,293	0	50.00
53.00	ANESTHESIOLOGY	250	250	0	250	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,063	2,063	0	2,063	0	54.00
60.00	LABORATORY	1,060	1,060	0	1,060	0	60.00
65.00	RESPIRATORY THERAPY	1,989	1,989	0	1,989	0	65.00
66.00	PHYSICAL THERAPY	120	120	0	120	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	354	354	0	354	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,219	1,219	0	1,219	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	2,794	2,794	0	2,794	0	88.01
90.00	CLINIC	1,589	1,589	0	1,589	0	90.00
91.00	EMERGENCY	396	396	0	396	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,152	26,963	100	24,993	100	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	900	900	0	900	0	192.00
192.01	MARKETING	0	0	0	0	0	192.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	407,166	311,385	140,262	291,917	479,872	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.548716	11.175573	1,402.620000	11.273974	4,798.720000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	37,212	45,773	29,954	16,529	50,860	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.238254	1.642788	299.540000	0.638358	508.600000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet B-1 | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		11.00	13.00	16.00	19.00		
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	235,486					11.00
13.00	NURSING ADMINISTRATION	5,630	77,312				13.00
16.00	MEDICAL RECORDS & LIBRARY	12,475	0	31,895,634			16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	53,933	53,933	3,562,485			30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,192	8,192	1,566,117	0		50.00
53.00	ANESTHESIOLOGY	0	0	744,414	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	17,239	0	7,558,819	0		54.00
60.00	LABORATORY	22,855	0	6,126,549	0		60.00
65.00	RESPIRATORY THERAPY	15,550	0	1,947,174	0		65.00
66.00	PHYSICAL THERAPY	8,711	0	958,739	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,314	0	1,358,580	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	53,501	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	7,847	0	2,823,606	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	35,455	0	1,503,835	0		88.01
90.00	CLINIC	14,318	0	1,451,579	0		90.00
91.00	EMERGENCY	15,187	15,187	2,240,236	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	223,706	77,312	31,895,634	0		118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	7,840	0	0	0		192.00
192.01	MARKETING	3,940	0	0	0		192.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	111,578	368,311	348,130	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.473820	4.763956	0.010915	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	8,496	27,660	16,851	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.036079	0.357771	0.000528	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,243,746		3,243,746	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	547,674		547,674	0	0	50.00
53.00	ANESTHESIOLOGY	302,307		302,307	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,636,760		1,636,760	0	0	54.00
60.00	LABORATORY	1,438,496		1,438,496	0	0	60.00
65.00	RESPIRATORY THERAPY	766,823	0	766,823	0	0	65.00
66.00	PHYSICAL THERAPY	428,565	0	428,565	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	395,043		395,043	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	6,715		6,715	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,098,417		1,098,417	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	490,128		490,128	0	0	88.00
88.01	RURAL HEALTH CLINIC II	1,426,635		1,426,635	0	0	88.01
90.00	CLINIC	841,818		841,818	0	0	90.00
91.00	EMERGENCY	1,265,108		1,265,108	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	540,769		540,769		0	92.00
200.00	Subtotal (see instructions)	14,429,004	0	14,429,004	0	0	200.00
201.00	Less Observation Beds	540,769		540,769		0	201.00
202.00	Total (see instructions)	13,888,235	0	13,888,235	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,013,303		3,013,303			30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	101,851	1,464,266	1,566,117	0.349702	0.000000	50.00
53.00	ANESTHESIOLOGY	39,633	704,781	744,414	0.406101	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	685,893	6,872,926	7,558,819	0.216536	0.000000	54.00
60.00	LABORATORY	923,814	5,202,735	6,126,549	0.234797	0.000000	60.00
65.00	RESPIRATORY THERAPY	658,196	1,288,978	1,947,174	0.393813	0.000000	65.00
66.00	PHYSICAL THERAPY	63,791	894,948	958,739	0.447009	0.000000	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	872,618	485,962	1,358,580	0.290776	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	3,431	50,070	53,501	0.125512	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,693,341	1,130,265	2,823,606	0.389012	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	477,157	477,157			88.00
88.01	RURAL HEALTH CLINIC II	0	1,503,835	1,503,835			88.01
90.00	CLINIC	0	1,451,579	1,451,579	0.579933	0.000000	90.00
91.00	EMERGENCY	70,209	2,170,027	2,240,236	0.564721	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	26,804	522,378	549,182	0.984681	0.000000	92.00
200.00	Subtotal (see instructions)	8,152,884	24,219,907	32,372,791			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,152,884	24,219,907	32,372,791			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio	
		11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	ADULTS & PEDIATRICS		30.00
	ANCILLARY SERVICE COST CENTERS		
50.00	OPERATING ROOM	0.000000	50.00
53.00	ANESTHESIOLOGY	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	LABORATORY	0.000000	60.00
65.00	RESPIRATORY THERAPY	0.000000	65.00
66.00	PHYSICAL THERAPY	0.000000	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS		
88.00	RURAL HEALTH CLINIC		88.00
88.01	RURAL HEALTH CLINIC II		88.01
90.00	CLINIC	0.000000	90.00
91.00	EMERGENCY	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/28/2012 4:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,243,746		3,243,746	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	547,674		547,674	0	0	50.00
53.00	ANESTHESIOLOGY	302,307		302,307	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,636,760		1,636,760	0	0	54.00
60.00	LABORATORY	1,438,496		1,438,496	0	0	60.00
65.00	RESPIRATORY THERAPY	766,823	0	766,823	0	0	65.00
66.00	PHYSICAL THERAPY	428,565	0	428,565	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	395,043		395,043	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	6,715		6,715	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,098,417		1,098,417	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	490,128		490,128	0	0	88.00
88.01	RURAL HEALTH CLINIC II	1,426,635		1,426,635	0	0	88.01
90.00	CLINIC	841,818		841,818	0	0	90.00
91.00	EMERGENCY	1,265,108		1,265,108	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	540,769		540,769		0	92.00
200.00	Subtotal (see instructions)	14,429,004	0	14,429,004	0	0	200.00
201.00	Less Observation Beds	540,769		540,769		0	201.00
202.00	Total (see instructions)	13,888,235	0	13,888,235	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/28/2012 4:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,013,303		3,013,303			30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	101,851	1,464,266	1,566,117	0.349702	0.000000	50.00
53.00	ANESTHESIOLOGY	39,633	704,781	744,414	0.406101	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	685,893	6,872,926	7,558,819	0.216536	0.000000	54.00
60.00	LABORATORY	923,814	5,202,735	6,126,549	0.234797	0.000000	60.00
65.00	RESPIRATORY THERAPY	658,196	1,288,978	1,947,174	0.393813	0.000000	65.00
66.00	PHYSICAL THERAPY	63,791	894,948	958,739	0.447009	0.000000	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	872,618	485,962	1,358,580	0.290776	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	3,431	50,070	53,501	0.125512	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,693,341	1,130,265	2,823,606	0.389012	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	477,157	477,157	1.027184	0.000000	88.00
88.01	RURAL HEALTH CLINIC II	0	1,503,835	1,503,835	0.948665	0.000000	88.01
90.00	CLINIC	0	1,451,579	1,451,579	0.579933	0.000000	90.00
91.00	EMERGENCY	70,209	2,170,027	2,240,236	0.564721	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	26,804	522,378	549,182	0.984681	0.000000	92.00
200.00	Subtotal (see instructions)	8,152,884	24,219,907	32,372,791			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,152,884	24,219,907	32,372,791			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet C Part I Date/Time Prepared: 8/28/2012 4:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio	
		11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	ADULTS & PEDIATRICS		30.00
	ANCILLARY SERVICE COST CENTERS		
50.00	OPERATING ROOM	0.000000	50.00
53.00	ANESTHESIOLOGY	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	LABORATORY	0.000000	60.00
65.00	RESPIRATORY THERAPY	0.000000	65.00
66.00	PHYSICAL THERAPY	0.000000	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS		
88.00	RURAL HEALTH CLINIC	0.000000	88.00
88.01	RURAL HEALTH CLINIC II	0.000000	88.01
90.00	CLINIC	0.000000	90.00
91.00	EMERGENCY	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part II Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	38,381	1,566,117	0.024507	46,425	1,138	50.00
53.00	ANESTHESIOLOGY	10,190	744,414	0.013689	14,448	198	53.00
54.00	RADIOLOGY-DIAGNOSTIC	71,527	7,558,819	0.009463	341,204	3,229	54.00
60.00	LABORATORY	47,384	6,126,549	0.007734	579,536	4,482	60.00
65.00	RESPIRATORY THERAPY	54,205	1,947,174	0.027838	424,007	11,804	65.00
66.00	PHYSICAL THERAPY	9,831	958,739	0.010254	31,672	325	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,194	1,358,580	0.010448	607,399	6,346	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	125	53,501	0.002336	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	43,680	2,823,606	0.015470	990,364	15,321	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	7,744	477,157	0.016229	0	0	88.00
88.01	RURAL HEALTH CLINIC II	81,615	1,503,835	0.054271	0	0	88.01
90.00	CLINIC	46,941	1,451,579	0.032338	0	0	90.00
91.00	EMERGENCY	33,663	2,240,236	0.015027	68	1	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	549,182	0.000000	0	0	92.00
200.00	Total (lines 50-199)	459,480	29,359,488		3,035,123	42,844	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part IV | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part IV | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	1,566,117	0.000000	0.000000	46,425	50.00
53.00	ANESTHESIOLOGY	0	744,414	0.000000	0.000000	14,448	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	7,558,819	0.000000	0.000000	341,204	54.00
60.00	LABORATORY	0	6,126,549	0.000000	0.000000	579,536	60.00
65.00	RESPIRATORY THERAPY	0	1,947,174	0.000000	0.000000	424,007	65.00
66.00	PHYSICAL THERAPY	0	958,739	0.000000	0.000000	31,672	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,358,580	0.000000	0.000000	607,399	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	53,501	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,823,606	0.000000	0.000000	990,364	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	477,157	0.000000	0.000000	0	88.00
88.01	RURAL HEALTH CLINIC II	0	1,503,835	0.000000	0.000000	0	88.01
90.00	CLINIC	0	1,451,579	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	2,240,236	0.000000	0.000000	68	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	549,182	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	29,359,488			3,035,123	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part IV | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.349702	0	643,612	0		50.00
53.00	ANESTHESIOLOGY	0.406101	0	352,398	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.216536	0	2,177,537	0		54.00
60.00	LABORATORY	0.234797	0	2,508,253	0		60.00
65.00	RESPIRATORY THERAPY	0.393813	0	737,455	0		65.00
66.00	PHYSICAL THERAPY	0.447009	0	289,165	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.290776	0	264,479	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.125512	0	16,526	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.389012	0	834,683	104		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
88.01	RURAL HEALTH CLINIC II	0.000000					88.01
90.00	CLINIC	0.579933	0	1,451,579	0		90.00
91.00	EMERGENCY	0.564721	0	443,128	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.984681	0	271,026	0		92.00
200.00	Subtotal (see instructions)		0	9,989,841	104		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	9,989,841	104		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Costs				
		PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	225,072	0		50.00
53.00	ANESTHESIOLOGY	0	143,109	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	471,515	0		54.00
60.00	LABORATORY	0	588,930	0		60.00
65.00	RESPIRATORY THERAPY	0	290,419	0		65.00
66.00	PHYSICAL THERAPY	0	129,259	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	76,904	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	2,074	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	324,702	40		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	CLINIC	0	841,819	0		90.00
91.00	EMERGENCY	0	250,244	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	266,874	0		92.00
200.00	Subtotal (see instructions)	0	3,610,921	40		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	3,610,921	40		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141324 | Component CCN: 14Z324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.349702	0	0	0		50.00
53.00	ANESTHESIOLOGY	0.406101	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.216536	0	0	0		54.00
60.00	LABORATORY	0.234797	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0.393813	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.447009	0	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.290776	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.125512	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.389012	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
88.01	RURAL HEALTH CLINIC II	0.000000					88.01
90.00	CLINIC	0.579933	0	0	0		90.00
91.00	EMERGENCY	0.564721	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.984681	0	0	0		92.00
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: 141324 | Component CCN: 14Z324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V Date/Time Prepared: 8/28/2012 4:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.349702	0	0	271,063		50.00
53.00	ANESTHESIOLOGY	0.406101	0	0	119,844		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.216536	0	0	1,814,289		54.00
60.00	LABORATORY	0.234797	0	0	870,991		60.00
65.00	RESPIRATORY THERAPY	0.393813	0	0	262,275		65.00
66.00	PHYSICAL THERAPY	0.447009	0	0	145,328		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.290776	0	0	82,289		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.125512	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.389012	0	0	176,241		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1.027184					88.00
88.01	RURAL HEALTH CLINIC II	0.948665					88.01
90.00	CLINIC	0.579933	0	0	0		90.00
91.00	EMERGENCY	0.564721	0	0	721,785		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.984681	0	0	0		92.00
200.00	Subtotal (see instructions)		0	0	4,464,105		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	4,464,105		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D Part V Date/Time Prepared: 8/28/2012 4:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Costs PPS Services (see instructions)	Costs Cost Services Subject To Ded. & Coins. (see instructions)	Costs Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	94,791		50.00
53.00	ANESTHESIOLOGY	0	0	48,669		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	392,859		54.00
60.00	LABORATORY	0	0	204,506		60.00
65.00	RESPIRATORY THERAPY	0	0	103,287		65.00
66.00	PHYSICAL THERAPY	0	0	64,963		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	23,928		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	68,560		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	407,607		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Subtotal (see instructions)	0	0	1,409,170		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	1,409,170		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-1 | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,864	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,576	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)	2,938	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	63	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)	188	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	9	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)	28	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,980	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)	63	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)	188	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,243,746	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	212,745	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,031,001	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,562,485	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,562,485	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.850811	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)	1,212.55	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)	3,031,001	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)	847.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,678,228	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,678,228	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-1 | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	975,113	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,653,341	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)	53,398	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	159,347	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	212,745	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)	638	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	847.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	540,769	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-1 | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-3 | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		1,863,180		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.349702	46,425	16,235	50.00
53.00	ANESTHESIOLOGY	0.406101	14,448	5,867	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.216536	341,204	73,883	54.00
60.00	LABORATORY	0.234797	579,536	136,073	60.00
65.00	RESPIRATORY THERAPY	0.393813	424,007	166,979	65.00
66.00	PHYSICAL THERAPY	0.447009	31,672	14,158	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.290776	607,399	176,617	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.125512	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.389012	990,364	385,263	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	CLINIC	0.579933	0	0	90.00
91.00	EMERGENCY	0.564721	68	38	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.984681	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,035,123	975,113	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)		3,035,123		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141324 | Component CCN: 14Z324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-3 | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.349702	1,283	449	50.00
53.00	ANESTHESIOLOGY	0.406101	340	138	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.216536	9,036	1,957	54.00
60.00	LABORATORY	0.234797	33,776	7,931	60.00
65.00	RESPIRATORY THERAPY	0.393813	60,471	23,814	65.00
66.00	PHYSICAL THERAPY	0.447009	18,327	8,192	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.290776	81,574	23,720	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.125512	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.389012	112,613	43,808	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	CLINIC	0.579933	0	0	90.00
91.00	EMERGENCY	0.564721	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.984681	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		317,420	110,009	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)		317,420		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet D-3 | Date/Time Prepared: 8/28/2012 4:19 pm

Title XIX | Hospital | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		552,498		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.349702	25,669	8,977	50.00
53.00	ANESTHESIOLOGY	0.406101	11,428	4,641	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.216536	120,262	26,041	54.00
60.00	LABORATORY	0.234797	132,037	31,002	60.00
65.00	RESPIRATORY THERAPY	0.393813	153,430	60,423	65.00
66.00	PHYSICAL THERAPY	0.447009	1,845	825	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.290776	7,893	2,295	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.125512	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.389012	292,694	113,861	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	1.027184	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0.948665	0	0	88.01
90.00	CLINIC	0.579933	0	0	90.00
91.00	EMERGENCY	0.564721	29,465	16,640	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.984681	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		774,723	264,705	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)		774,723		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141324	Period: From 04/01/2011 To 03/31/2012	Worksheet E Part B Date/Time Prepared: 8/28/2012 4:19 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,610,961	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)	3,610,961	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)	3,647,071	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)	50,798	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,480,854	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)	2,115,419	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)	2,115,419	30.00
31.00	Primary payer payments	76	31.00
32.00	Subtotal (line 30 minus line 31)	2,115,343	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)	418,327	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	418,327	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	394,076	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,533,670	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)	2,533,670	40.00
41.00	Interim payments	2,768,753	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)	-235,083	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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 8/28/2012 4:19 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,986,076		2,532,661	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		105,881		476,593	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	03/23/2012	9,989		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	10/31/2011	87,425	10/31/2011	199,153	3.50
3.51			0	03/23/2012	41,348	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)		-77,436		-240,501	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,014,521		2,768,753	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		359,327		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		235,083	6.02
7.00	Total Medicare program liability (see instructions)		2,373,848		2,533,670	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: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 8/28/2012 4:19 pm

Component CCN: 14Z324 | 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		313,138		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		0		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	10/31/2011	6,734		0	3.50
3.51		03/23/2012	1,396		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)		-8,130		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)		305,008		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		19,678		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		324,686		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: 141324 Component CCN: 14Z324	Period: From 04/01/2011 To 03/31/2012	Worksheet E-2 Date/Time Prepared: 8/28/2012 4:19 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	214,872	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)	111,109	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	251	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)	325,981	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	325,981	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)	325,981	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,295	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)	324,686	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)	324,686	0	19.00
20.00	Interim payments	305,008	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)	19,678	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: 141324	Period: From 04/01/2011 To 03/31/2012	Worksheet E-3 Part V Date/Time Prepared: 8/28/2012 4:19 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,653,341	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,653,341	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,679,874	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,679,874	19.00
20.00	Deductibles (exclude professional component)	413,424	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	2,266,450	22.00
23.00	Coinsurance	9,056	23.00
24.00	Subtotal (line 22 minus line 23)	2,257,394	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	116,454	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	116,454	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	109,775	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,373,848	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,373,848	30.00
31.00	Interim payments	2,014,521	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)	359,327	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	90,515	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet G | Date/Time Prepared: 8/28/2012 4:19 pm

		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	370,597	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	8,941,972	0	0	0	4.00
5.00	Other receivable	1,597,940	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,453,515	0	0	0	6.00
7.00	Inventory	261,573	0	0	0	7.00
8.00	Prepaid expenses	65,226	0	0	0	8.00
9.00	Other current assets	171,759	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)	5,955,552	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	6,338,730	0	0	0	15.00
16.00	Accumulated depreciation	-3,159,882	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	3,178,848	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	11,543	0	0	0	33.00
34.00	Other assets	21,767	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	33,310	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,167,710	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,768,795	0	0	0	37.00
38.00	Salaries, wages, and fees payable	929,331	0	0	0	38.00
39.00	Payroll taxes payable	-1,022	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,276,402	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	840,513	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,814,019	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,478,574	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,478,574	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	9,292,593	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-124,883				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)	-124,883	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,167,710	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet G-1 | Date/Time Prepared: 8/28/2012 4:19 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		-1,064,896		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,262,825				2.00
3.00	Total (sum of line 1 and line 2)		197,929		0		3.00
4.00	Additions (credit adjustments) (specify)	4		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)		4		0		10.00
11.00	Subtotal (line 3 plus line 10)		197,933		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)		197,933		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet G-1 | Date/Time Prepared: 8/28/2012 4:19 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141324 | Period: From 04/01/2011 To 03/31/2012 | Worksheet G-2 Parts | Date/Time Prepared: 8/28/2012 4:19 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,562,485		3,562,485	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	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)	3,562,485		3,562,485	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)	3,562,485		3,562,485	17.00
18.00	Ancillary services	5,112,777	21,716,537	26,829,314	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	90,059	1,800,192	1,890,251	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,765,321	23,516,729	32,282,050	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,213,169		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	OTHER OPERATING EXPENSE	2,320,548			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)		2,320,548		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,892,621		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141324	Period: From 04/01/2011 To 03/31/2012	Worksheet G-3 Date/Time Prepared: 8/28/2012 4:19 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	32,282,050	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,070,031	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,212,019	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,892,621	4.00
5.00	Net income from service to patients (line 3 minus line 4)	319,398	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	994,423	24.00
25.00	Total other income (sum of lines 6-24)	994,423	25.00
26.00	Total (line 5 plus line 25)	1,313,821	26.00
27.00	NET NON OPERATING INCOME	50,996	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	50,996	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,262,825	29.00

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

Provider CCN: 141324 Component CCN: 148507 | Period: From 04/01/2011 To 03/31/2012 | Worksheet M-1 | Date/Time Prepared: 8/28/2012 4:19 pm

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	163,974	0	163,974	0	163,974	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	163,974	0	163,974	0	163,974	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	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	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	163,974	0	163,974	0	163,974	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	72,195	43,535	115,730	43,031	158,761	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	72,195	43,535	115,730	43,031	158,761	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	236,169	43,535	279,704	43,031	322,735	32.00

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

Provider CCN: 141324 | Component CCN: 148507 | Period: From 04/01/2011 To 03/31/2012 | Worksheet M-1 | Date/Time Prepared: 8/28/2012 4:19 pm

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	163,974		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	163,974		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	0		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	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	163,974		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	158,761		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	158,761		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	322,735		32.00

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

Provider CCN: 141324 Component CCN: 148506 | Period: From 04/01/2011 To 03/31/2012 | Worksheet M-1 | Date/Time Prepared: 8/28/2012 4:19 pm

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

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	411,193	0	411,193	0	411,193	1.00
2.00	Physician Assistant	163,252	0	163,252	0	163,252	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	574,445	0	574,445	0	574,445	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	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	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	574,445	0	574,445	0	574,445	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	39,590	211,302	250,892	8,922	259,814	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	39,590	211,302	250,892	8,922	259,814	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	614,035	211,302	825,337	8,922	834,259	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141324 Component CCN: 148506	Period: From 04/01/2011 To 03/31/2012	Worksheet M-1 Date/Time Prepared: 8/28/2012 4:19 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	411,193		1.00
2.00	Physician Assistant	0	163,252		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	574,445		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	0		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	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	574,445		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	259,814		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	259,814		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	834,259		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141324 Component CCN: 148507 | Period: From 04/01/2011 To 03/31/2012 | Worksheet M-2 Date/Time Prepared: 8/28/2012 4:19 pm

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	3,389	4,200	4,200		1.00
2.00	Physician Assistant	0.40	604	2,100	840		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	1.40	3,993		5,040	5,040	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.40	3,993			5,040	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)					163,974	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)					163,974	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)					158,761	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					167,393	15.00
16.00	Total overhead (sum of lines 14 and 15)					326,154	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					326,154	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					326,154	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					490,128	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141324 Component CCN: 148506 | Period: From 04/01/2011 To 03/31/2012 | Worksheet M-2 Date/Time Prepared: 8/28/2012 4:19 pm

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

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.00	9,421	4,200	8,400		1.00
2.00	Physician Assistant	0.75	1,958	2,100	1,575		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	2.75	11,379		9,975	11,379	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)	2.75	11,379			11,379	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)					574,445	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)					574,445	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)					259,814	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					592,376	15.00
16.00	Total overhead (sum of lines 14 and 15)					852,190	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					852,190	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					852,190	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,426,635	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141324 Component CCN: 148507	Period: From 04/01/2011 To 03/31/2012	Worksheet M-3 Date/Time Prepared: 8/28/2012 4:19 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		490,128	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		490,128	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,040	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,040	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		97.25	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	97.25	97.25	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	690	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	67,103	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	67,103	16.00
16.01	Total program charges (see instructions)(from contractor's records)		56,869	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.)		46,907	16.04
16.05	Total program cost (see instructions)		46,907	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,469	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)		46,907	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)		46,907	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)		46,907	26.00
27.00	Interim payments		65,218	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)		-18,311	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141324 Component CCN: 148506 | Period: From 04/01/2011 To 03/31/2012 | Worksheet M-3 | Date/Time Prepared: 8/28/2012 4:19 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,426,635	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,426,635	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		11,379	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)		11,379	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		125.37	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	125.37	125.37	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,152	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	395,166	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	395,166	16.00
16.01	Total program charges (see instructions)(from contractor's records)		261,835	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.)		297,573	16.04
16.05	Total program cost (see instructions)		297,573	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		23,200	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)		297,573	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)		297,573	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)		297,573	26.00
27.00	Interim payments		322,271	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		-24,698	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141324 Component CCN: 148507	Period: From 04/01/2011 To 03/31/2012	Worksheet M-5 Date/Time Prepared: 8/28/2012 4:19 pm
	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		67,843	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		10/31/2011	2,625	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)		-2,625	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		65,218	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		18,311	6.02
7.00	Total Medicare program liability (see instructions)		46,907	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141324 Component CCN: 148506	Period: From 04/01/2011 To 03/31/2012	Worksheet M-5 Date/Time Prepared: 8/28/2012 4:19 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		322,271	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		322,271	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		24,698	6.02
7.00	Total Medicare program liability (see instructions)		297,573	7.00

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