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: 141348

Period:
From 07/01/2011
To 06/30/2012

Worksheet S
Parts I-III
Date/Time Prepared:
11/28/2012 3:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2012 Time: 3:05 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 RED BUD REGIONAL HOSPITAL for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 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	137,881	-1,306,982	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	124,844	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		146,856		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	262,725	-1,160,126	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2012 12:10 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: ST. CLEMENT BLVD	PO Box:			1.00
2.00	City: RED BUD	State: IL	Zip Code: 62278-	County: RANDOLPH	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	RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	N	O	P	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	RED BUD HOSPITAL	14Z348	99914		08/10/2005	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA						N	N	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2011	06/30/2012	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	3	N	23.00

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	2		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2012 12:10 pm

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

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

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2012 12:10 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (see instructions)			0.00	0.00	0.000000	65.00

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2012 12:10 pm

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

		1.00	
	Long Term Care Hospital PPS		
80.00	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	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	Y	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00

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		1.00	2.00	3.00	
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.	1			118.00

		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.	32,494	741,588	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)	Y	449008	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: CHS / COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 522280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 11/28/2012 12:10 pm

		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
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2012 12:10 pm

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

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

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

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/08/2012	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: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 11/28/2012 12:10 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.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		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.			Y		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.			Y	12/31/2011	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		JULIE	MARSHALL		41.00
42.00	Enter the employer/company name of the cost report preparer.		COMMUNITY HEALTH SYSTEMS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		6154657546	JULIE_CATO@CHS.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2012 12:10 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	10/08/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
			3.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REVENUE MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2012 12:10 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	64,800.00		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	64,800.00		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	64,800.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0			17.00
18.00	SUBPROVIDER	42.00	0	0			18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10					25.10
26.00	RURAL HEALTH CLINIC	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days						28.00
28.02	SUBPROVIDER - IRF	41.00					28.02
28.03	SUBPROVIDER	42.00					28.03
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2012 12:10 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	1,991	152	2,736		1.00
2.00	HMO		218	6			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	2,984	0	2,984		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	375		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	4,975	152	6,095		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	4,975	152	6,095		14.00
15.00	CAH visits	0	3,868	0	5,316		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0		17.00
18.00	SUBPROVIDER	0	0	0	0		18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0		25.10
26.00	RURAL HEALTH CLINIC	0	4,257	0	7,356		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	207		28.00
28.02	SUBPROVIDER - IRF				0		28.02
28.03	SUBPROVIDER				0		28.03
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: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2012 12:10 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	574	1.00
2.00	HMO					49	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	137.65	0.00	0	574	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00	SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00	0.00	0.00			25.10
26.00	RURAL HEALTH CLINIC	0.00	10.49	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00	Total (sum of lines 14-26)	0.00	148.14	0.00			27.00
28.00	Observation Bed Days						28.00
28.02	SUBPROVIDER - IRF						28.02
28.03	SUBPROVIDER						28.03
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2012 12:10 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)	66	870		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)	66	870		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF	0	0		17.00
18.00	SUBPROVIDER	0	0		18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
25.10	CMHC - CORF				25.10
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
28.02	SUBPROVIDER - IRF				28.02
28.03	SUBPROVIDER				28.03
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

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

Provider CCN: 141348 Component CCN: 148514 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-8 | Date/Time Prepared: 11/28/2012 12:10 pm

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			325 SPRING STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	RED BUD		IL	62278	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic			09:00	05:00	11.00
				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	Provider name, CCN number			OLDER ADULT HEALTH CENTER	141348	14.00

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/28/2012 12:10 pm
		Rural Health Clinic (RHC) I	Cost

		County					
		4.00					
2.00	City, State, Zip Code, County	RANDOLPH					2.00
		Tuesday		Wednesday			
		from	to	from	to		
		5.00	6.00	7.00	8.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	05:00	09:00	05:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/28/2012 12:10 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	09:00	05:00	09:00	05:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/28/2012 12:10 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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet S-10 | Date/Time Prepared: 11/28/2012 12:10 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)	0.186756	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	679,757	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	490,090	5.00
6.00	Medicaid charges	8,095,270	6.00
7.00	Medicaid cost (line 1 times line 6)	1,511,840	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)	341,993	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)	341,993	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	518,551	6,677	525,228	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	96,843	1,247	98,090	21.00
22.00	Partial payment by patients approved for charity care	1,400	0	1,400	22.00
23.00	Cost of charity care (line 21 minus line 22)	95,443	1,247	96,690	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)	831,175	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	333,689	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	497,486	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	92,908	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	189,598	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	531,591	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		203,221	203,221	58,678	261,899	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		872,810	872,810	274,180	1,146,990	2.00
4.00	00400	EMPLOYEE BENEFITS	110,764	164,010	274,774	1,213,021	1,487,795	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,437,314	7,084,845	8,522,159	-1,583,742	6,938,417	5.00
7.00	00700	OPERATION OF PLANT	226,922	943,132	1,170,054	-66,354	1,103,700	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	107,570	107,570	0	107,570	8.00
9.00	00900	HOUSEKEEPING	149,531	45,434	194,965	-12,267	182,698	9.00
10.00	01000	DIETARY	0	915,349	915,349	-140,152	775,197	10.00
11.00	01100	CAFETERIA	0	0	0	140,012	140,012	11.00
13.00	01300	NURSING ADMINISTRATION	772,188	79,192	851,380	-67,576	783,804	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,129	252,938	286,067	-206,324	79,743	14.00
15.00	01500	PHARMACY	226,262	623,639	849,901	-564,639	285,262	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	205,985	147,868	353,853	-9,490	344,363	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,223,000	275,261	1,498,261	-25,033	1,473,228	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	388,168	96,358	484,526	-29,184	455,342	50.00
53.00	05300	ANESTHESIOLOGY	381,879	69,541	451,420	-922	450,498	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	642,560	717,503	1,360,063	-146,324	1,213,739	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	386,628	697,922	1,084,550	-15,381	1,069,169	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	175,003	62,601	237,604	-32,731	204,873	65.00
66.00	06600	PHYSICAL THERAPY	392,008	39,106	431,114	0	431,114	66.00
67.00	06700	OCCUPATIONAL THERAPY	77,272	28,678	105,950	0	105,950	67.00
68.00	06800	SPEECH PATHOLOGY	0	45,128	45,128	0	45,128	68.00
69.00	06900	ELECTROCARDIOLOGY	21,577	56,658	78,235	0	78,235	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	201,429	201,429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,280	25,280	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	540,061	540,061	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	649,341	171,849	821,190	71,488	892,678	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,829,528	406,695	2,236,223	-7,536	2,228,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,329,059	14,107,308	23,436,367	-383,506	23,052,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-57,256	-57,256	11,756	-45,500	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	83,929	83,929	194.01
194.02	07952	SENIOR CIRCLE	8,098	385	8,483	243	8,726	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	53,492	53,492	0	53,492	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	276,102	276,102	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	11,476	11,476	194.06
200.00		TOTAL (SUM OF LINES 118-199)	9,337,157	14,103,929	23,441,086	0	23,441,086	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	200,958	462,857		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-19,857	1,127,133		2.00
4.00	00400	EMPLOYEE BENEFITS	-62,453	1,425,342		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,143,797	3,794,620		5.00
7.00	00700	OPERATION OF PLANT	-24	1,103,676		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	107,570		8.00
9.00	00900	HOUSEKEEPING	0	182,698		9.00
10.00	01000	DIETARY	438,490	1,213,687		10.00
11.00	01100	CAFETERIA	-59,306	80,706		11.00
13.00	01300	NURSING ADMINISTRATION	-375	783,429		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	79,743		14.00
15.00	01500	PHARMACY	0	285,262		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-26	344,337		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,473,228		30.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	455,342		50.00
53.00	05300	ANESTHESIOLOGY	-417,044	33,454		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-558	1,213,181		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	1,069,169		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	204,873		65.00
66.00	06600	PHYSICAL THERAPY	0	431,114		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	105,950		67.00
68.00	06800	SPEECH PATHOLOGY	0	45,128		68.00
69.00	06900	ELECTROCARDIOLOGY	-13,665	64,570		69.00
70.10	07001	CARDIAC REHAB	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	201,429		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,280		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,809	538,252		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-84	892,594		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-1,087,779	1,140,908		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,167,329	18,885,532		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-60	-60		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	74,589	29,089		192.00
194.00	07950	HOME HEALTH	0	0		194.00
194.01	07951	MARKETING	0	83,929		194.01
194.02	07952	SENIOR CIRCLE	-5,601	3,125		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	-49,599	3,893		194.04
194.05	07955	FREE STANDING NURSING HOME	0	276,102		194.05
194.06	07956	CLINIC CORPORATION	0	11,476		194.06
200.00		TOTAL (SUM OF LINES 118-199)	-4,148,000	19,293,086		200.00

RECLASSIFICATIONS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 11/28/2012 12:10 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS OF EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	1,269,679		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,269,679		
	B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,585		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	10,585		
	C - RECLASS RENTAL AND LEASE EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	293,876		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	293,876		
	D - RECLASS OTHER CAPITAL COSTS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	58,678		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,779		2.00
	TOTALS		0	62,457		
	E - RECLASS MARKETING					
1.00	MARKETING	194.01	39,425	44,504		1.00
	TOTALS		39,425	44,504		
	F - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	190,844		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	25,280		2.00
	TOTALS		0	216,124		
	G - RECLASS COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	540,061		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	540,061		
	H - RECLASS DIETARY PORTION					
1.00	CAFETERIA	11.00	0	140,012		1.00
	TOTALS		0	140,012		
	I - RECLASS NURSING HOME SERVICES					
1.00	FREE STANDING NURSING HOME	194.05	240,832	35,270		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		240,832	35,270		
	J - RECLASS CLINIC CORPORATION SERVICES					
1.00	RURAL HEALTH CLINIC	88.00	73,965	7,327		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		73,965	7,327		
	K - DIRECTLY ALLOCATED DEPRECIATION					
1.00	CLINIC CORPORATION	194.06	0	11,476		1.00
	TOTALS		0	11,476		
	L - DIRECTLY ALLOCATE DEPRECIATION					
1.00	SENIOR CIRCLE	194.02	0	243		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,756		2.00
	TOTALS		0	11,999		
500.00	Grand Total: Increases		354,222	2,643,370		500.00

RECLASSIFICATIONS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-6 | Date/Time Prepared: 11/28/2012 12:10 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS OF EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,262,239	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	7,440	0		2.00
	TOTALS		0	1,269,679			
	B - RECLASS OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	53	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	10,532	0		2.00
	TOTALS		0	10,585			
	C - RECLASS RENTAL AND LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,676	10		1.00
2.00	OPERATION OF PLANT	7.00	0	826	0		2.00
3.00	HOUSEKEEPING	9.00	0	7	0		3.00
4.00	DIETARY	10.00	0	140	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	28	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	14,960	0		6.00
7.00	PHARMACY	15.00	0	25,032	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,531	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	25,033	0		9.00
10.00	OPERATING ROOM	50.00	0	4,371	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	468	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	146,324	0		12.00
13.00	LABORATORY	60.00	0	15,381	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	22,199	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	2,364	0		15.00
16.00	EMERGENCY	91.00	0	7,536	0		16.00
	TOTALS		0	293,876			
	D - RECLASS OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,457	14		1.00
2.00		0.00	0	0	14		2.00
	TOTALS		0	62,457			
	E - RECLASS MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	39,425	44,504	0		1.00
	TOTALS		39,425	44,504			
	F - RECLASS MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	24,760	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	191,364	0		2.00
	TOTALS		0	216,124			
	G - RECLASS COST OF DRUGS						
1.00	PHARMACY	15.00	0	539,607	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	454	0		2.00
	TOTALS		0	540,061			
	H - RECLASS DIETARY PORTION						
1.00	DIETARY	10.00	0	140,012	0		1.00
	TOTALS		0	140,012			
	I - RECLASS NURSING HOME SERVICES						
1.00	EMPLOYEE BENEFITS	4.00	32,866	6,555	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	93,499	3,050	0		2.00
3.00	OPERATION OF PLANT	7.00	42,986	22,542	0		3.00
4.00	HOUSEKEEPING	9.00	12,260		0		4.00
5.00	NURSING ADMINISTRATION	13.00	53,262	3,123	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	5,959		0		6.00
	TOTALS		240,832	35,270			
	J - RECLASS CLINIC CORPORATION SERVICES						
1.00	EMPLOYEE BENEFITS	4.00	14,371	2,866	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	49,796	3,096	0		2.00
3.00	NURSING ADMINISTRATION	13.00	9,798	1,365	0		3.00
	TOTALS		73,965	7,327			
	K - DIRECTLY ALLOCATED DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	11,476	9		1.00
	TOTALS		0	11,476			
	L - DIRECTLY ALLOCATE DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	11,999	9		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	11,999			
500.00	Grand Total: Decreases		354,222	2,643,370			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/28/2012 12:10 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	0	0	0	0	0	1.00
2.00	Land Improvements	55,767	0	0	0	0	2.00
3.00	Buildings and Fixtures	95,669	587	0	587	0	3.00
4.00	Building Improvements	6,202,626	113,489	0	113,489	15,401	4.00
5.00	Fixed Equipment	802,327	239,936	0	239,936	0	5.00
6.00	Movable Equipment	10,954,255	2,236,726	0	2,236,726	980,452	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,110,644	2,590,738	0	2,590,738	995,853	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,110,644	2,590,738	0	2,590,738	995,853	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	203,221	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	870,747	2,063	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,073,968	2,063	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	6,452,738	0	6,452,738	0.327458	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	13,252,792	0	13,252,792	0.672542	0	2.00
3.00	Total (sum of lines 1-2)	19,705,530	0	19,705,530	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/28/2012 12:10 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0				1.00
2.00	Land Improvements	55,767	0				2.00
3.00	Buildings and Fixtures	96,256	0				3.00
4.00	Building Improvements	6,300,714	0				4.00
5.00	Fixed Equipment	1,042,263	0				5.00
6.00	Movable Equipment	12,210,529	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	19,705,529	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	19,705,529	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	203,221				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	872,810				2.00
3.00	Total (sum of lines 1-2)	0	1,076,031				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	386,912	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	773,899	295,939	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,160,811	295,939	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 11/28/2012 12:10 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	75,945	462,857	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	57,295	1,127,133	2.00
3.00	Total (sum of lines 1-2)	0	0	0	133,240	1,589,990	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/28/2012 12:10 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
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)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-11,394	ADMINISTRATIVE & GENERAL	5.00	7.00
8.00	Television and radio service (chapter 21)	A	-427	NEW CAP REL COSTS-MVBLE EQUIP	2.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,095,759			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-558	RADIOLOGY-DIAGNOSTIC	54.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,380,784			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-59,306	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients	B	-1,809	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00	Sale of medical records and abstracts	B	-26	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	-60	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	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	A	169,171	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A	-69,705	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	FEES FROM INSERVICE EDUCATION	B	-50	NURSING ADMINISTRATION	13.00	33.00
34.00	FITNESS REVENUE	B	-30	ADMINISTRATIVE & GENERAL	5.00	34.00
35.00	RENTAL INCOME - SBC & RB SPEC CLINIC	B	-45,600	NEW CAP REL COSTS-BLDG & FIXT	1.00	35.00
36.00	OTHER MISC REVENUE	B	-761	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	HOSPITAL BAD DEBT	A	-1,284,219	ADMINISTRATIVE & GENERAL	5.00	37.00
38.00	TELEPHONE SERVICES	A	-568	EMPLOYEE BENEFITS	4.00	38.00
38.01	TELEPHONE SERVICES	A	-24	OPERATION OF PLANT	7.00	38.01
38.02	TELEPHONE SERVICES	A	-84	RURAL HEALTH CLINIC	88.00	38.02
38.03	TELEPHONE SERVICES	A	-232	WATERLOO SPECIALTY CLINIC	194.04	38.03
38.04	TELEPHONE DEPRECIATION	A	-3,241	NEW CAP REL COSTS-MVBLE EQUIP	2.00	38.04
39.00	ADVERTISING	A	-66,811	ADMINISTRATIVE & GENERAL	5.00	39.00
39.01	PENALTIES	A	-8,395	ADMINISTRATIVE & GENERAL	5.00	39.01
40.00			0		0.00	40.00
41.00	PHYSICIAN RECRUITING	A	-29,641	ADMINISTRATIVE & GENERAL	5.00	41.00
42.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-8,046	ADMINISTRATIVE & GENERAL	5.00	42.00
43.00			0		0.00	43.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/28/2012 12:10 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
44.00	SPECIAL EVENTS	A	-11,413	ADMINISTRATIVE & GENERAL	5.00	44.00
44.01	SPECIAL EVENTS	A	-83	SENIOR CIRCLE	194.02	44.01
45.00			0		0.00	45.00
45.01	CRNA COSTS	A	-417,044	ANESTHESIOLOGY	53.00	45.01
45.02	CRNA BENEFITS	A	-61,885	EMPLOYEE BENEFITS	4.00	45.02
45.03	ILLINOIS PROVIDER TAX	A	-212,921	ADMINISTRATIVE & GENERAL	5.00	45.03
45.04	ADD BACK NH CREDIT FOR DIETARY	A	438,490	DIETARY	10.00	45.04
45.05	REMOVAL OF LEASE REVENUE	A	74,589	PHYSICIANS' PRIVATE OFFICES	192.00	45.05
45.06	LEGAL FEES	A	-9,682	ADMINISTRATIVE & GENERAL	5.00	45.06
45.07	TELEPHONE SERVICES	A	-325	NURSING ADMINISTRATION	13.00	45.07
45.08	REMOVAL OF LEASE REVENUE	A	-49,367	WATERLOO SPECIALTY CLINIC	194.04	45.08
45.09			0		0.00	45.09
45.10			0		0.00	45.10
45.11			0		0.00	45.11
45.12			0		0.00	45.12
45.13			0		0.00	45.13
45.14			0		0.00	45.14
45.15			0		0.00	45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,148,000			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/28/2012 12:10 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
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)	9		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	9		26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	9		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	FEES FROM INSERVICE EDUCATION	0		33.00
34.00	FITNESS REVENUE	0		34.00
35.00	RENTAL INCOME - SBC & RB SPEC CLINIC	9		35.00
36.00	OTHER MISC REVENUE	0		36.00
37.00	HOSPITAL BAD DEBT	0		37.00
38.00	TELEPHONE SERVICES	0		38.00
38.01	TELEPHONE SERVICES	0		38.01
38.02	TELEPHONE SERVICES	0		38.02
38.03	TELEPHONE SERVICES	0		38.03
38.04	TELEPHONE DEPRECIATION	9		38.04
39.00	ADVERTISING	0		39.00
39.01	PENALTIES	0		39.01
40.00		0		40.00
41.00	PHYSICIAN RECRUITING	0		41.00
42.00	LOBBYING EXPENSE IN ASSOCIATION DUES	0		42.00
43.00		0		43.00
44.00	SPECIAL EVENTS	0		44.00
44.01	SPECIAL EVENTS	0		44.01
45.00		0		45.00
45.01	CRNA COSTS	0		45.01
45.02	CRNA BENEFITS	0		45.02
45.03	ILLINOIS PROVIDER TAX	0		45.03
45.04	ADD BACK NH CREDIT FOR DIETARY	0		45.04
45.05	REMOVAL OF LEASE REVENUE	0		45.05
45.06	LEGAL FEES	0		45.06
45.07	TELEPHONE SERVICES	0		45.07
45.08	REMOVAL OF LEASE REVENUE	0		45.08
45.09		0		45.09

ADJUSTMENTS TO EXPENSES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8 | Date/Time Prepared: 11/28/2012 12:10 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
45.10		0		45.10
45.11		0		45.11
45.12		0		45.12
45.13		0		45.13
45.14		0		45.14
45.15		0		45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2012 12:10 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		1.00	NEW CAP REL COSTS-BLDG & FIXT	DIRECT CAPITAL INTEREST	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	2.00
3.00		1.00	NEW CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSS	3.00
4.00		1.00	NEW CAP REL COSTS-BLDG & FIXT	POOLED CAPITAL	4.00
4.01		2.00	NEW CAP REL COSTS-MVBLE EQUIP	POOLED CAPITAL	4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COSTS	4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	4.03
4.04		5.00	ADMINISTRATIVE & GENERAL	INTEREST	4.04
4.05		91.00	EMERGENCY	ER	4.05
4.06		194.02	SENIOR CIRCLE	SENIOR CIRCLE	4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		B	CHS	100.00		6.00
7.00		B	PASI	100.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2012 12:10 pm

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		60,120	0	60,120	9		1.00
2.00		76,360	0	76,360	0		2.00
3.00		8,691	0	8,691	14		3.00
4.00		8,576	0	8,576	14		4.00
4.01		53,516	0	53,516	14		4.01
4.02		414,858	683,525	-268,667	0		4.02
4.03		774,082	483,931	290,151	0		4.03
4.04		0	1,590,458	-1,590,458	0		4.04
4.05		0	13,555	-13,555	0		4.05
4.06		0	5,518	-5,518	0		4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,396,203	2,776,987	-1,380,784			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		COMMUNITY HEALTH SYSTEMS	100.00	HOSPITAL MANAGEMENT COMPA	6.00
7.00		PASI	100.00	COLLECTION AGENCY	7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2012 12:10 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		88.00	RURAL HEALTH CLINIC	229,039	0	1.00
2.00		69.00	ELECTROCARDIOLOGY	13,665	13,665	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	9,525	7,870	3.00
4.00		91.00	EMERGENCY	1,074,224	1,074,224	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				1,326,453	1,095,759	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2012 12:10 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		229,039	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		1,655	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		230,694		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2012 12:10 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: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2012 12:10 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	0		1.00
2.00		0	13,665		2.00
3.00		0	7,870		3.00
4.00		0	1,074,224		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	1,095,759		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2012 12:10 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	795.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.09	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.54	33.54	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					53,387	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					53,387	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					53,387	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					53,387	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					12,242	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					12,242	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,278	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					13,520	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					13,250	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/28/2012 12:10 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.09	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	53,387	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	13,250	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	66,637	63.00
64.00	Total cost of outside supplier services (from your records)	44,736	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	12,242	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,278	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,520	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,278	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,278	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	462,857	462,857				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,127,133		1,127,133			2.00
4.00	00400	EMPLOYEE BENEFITS	1,425,342	3,957	10,930	1,440,229		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,794,620	79,476	206,074	194,843	4,275,013	5.00
7.00	00700	OPERATION OF PLANT	1,103,676	115,547	319,169	28,566	1,566,958	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	107,570	825	2,278	0	110,673	8.00
9.00	00900	HOUSEKEEPING	182,698	6,805	18,799	21,319	229,621	9.00
10.00	01000	DIETARY	1,213,687	21,347	58,966	0	1,294,000	10.00
11.00	01100	CAFETERIA	80,706	10,524	29,070	0	120,300	11.00
13.00	01300	NURSING ADMINISTRATION	783,429	11,447	31,620	110,130	936,626	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	79,743	0	0	5,145	84,888	14.00
15.00	01500	PHARMACY	285,262	0	0	35,139	320,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	344,337	11,061	30,554	31,065	417,017	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,473,228	41,105	113,544	189,937	1,817,814	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	455,342	27,040	74,693	60,284	617,359	50.00
53.00	05300	ANESTHESIOLOGY	33,454	791	2,184	59,307	95,736	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,213,181	21,691	59,917	99,792	1,394,581	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,069,169	10,607	29,300	60,045	1,169,121	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	204,873	2,784	7,691	27,179	242,527	65.00
66.00	06600	PHYSICAL THERAPY	431,114	11,920	32,926	60,880	536,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	105,950	1,876	5,183	12,001	125,010	67.00
68.00	06800	SPEECH PATHOLOGY	45,128	764	2,111	0	48,003	68.00
69.00	06900	ELECTROCARDIOLOGY	64,570	3,734	10,314	3,351	81,969	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	201,429	3,174	8,767	0	213,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,280	0	0	0	25,280	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	538,252	5,353	14,786	0	558,391	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	892,594	8,179	22,592	112,332	1,035,697	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,140,908	10,744	29,677	284,131	1,465,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,885,532	410,751	1,121,145	1,395,446	18,782,655	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-60	2,020	0	0	1,960	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,089	45,278	0	0	74,367	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	83,929	2,168	5,988	6,123	98,208	194.01
194.02	07952	SENIOR CIRCLE	3,125	2,640	0	1,258	7,023	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	3,893	0	0	0	3,893	194.04
194.05	07955	FREE STANDING NURSING HOME	276,102	0	0	37,402	313,504	194.05
194.06	07956	CLINIC CORPORATION	11,476	0	0	0	11,476	194.06
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)	19,293,086	462,857	1,127,133	1,440,229	19,293,086	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,275,013					5.00
7.00	00700	OPERATION OF PLANT	458,354	2,025,312				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,373	6,330	149,376			8.00
9.00	00900	HOUSEKEEPING	67,167	52,233	13,963	362,984		9.00
10.00	01000	DIETARY	378,511	163,843	10,016	30,239	1,876,609	10.00
11.00	01100	CAFETERIA	35,189	80,774	0	14,908	0	11.00
13.00	01300	NURSING ADMINISTRATION	273,974	87,859	0	16,215	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,831	0	0	0	0	14.00
15.00	01500	PHARMACY	93,721	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	121,982	84,897	0	15,669	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	531,732	315,491	61,821	58,227	215,569	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	180,585	207,540	19,692	38,304	0	50.00
53.00	05300	ANESTHESIOLOGY	28,004	6,068	0	1,120	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	407,932	166,485	13,006	30,726	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	341,982	81,413	223	15,026	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	70,942	21,370	0	3,944	0	65.00
66.00	06600	PHYSICAL THERAPY	157,032	91,488	8,337	16,885	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,567	14,401	0	2,658	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,041	5,865	0	1,082	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,977	28,657	1,320	5,289	0	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,413	24,360	0	4,496	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,395	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,336	41,084	0	7,582	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	302,954	62,773	398	11,585	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	428,665	82,458	17,442	15,219	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,243,659	1,625,389	146,218	289,174	215,569	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	573	15,505	0	2,862	7,664	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	347,515	670	64,137	26,068	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	28,727	16,637	0	3,071	0	194.01
194.02	07952	SENIOR CIRCLE	2,054	20,266	923	3,740	16,796	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	1,565	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	1,610,512	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
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)	4,275,013	2,025,312	149,376	362,984	1,876,609	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	251,171					11.00
13.00	01300	NURSING ADMINISTRATION	20,557	1,335,231				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,291	0	113,010			14.00
15.00	01500	PHARMACY	5,320	89,304	0	508,746		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,299	0	583	0	653,447	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,074	482,707	19,190	0	62,659	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,891	153,206	0	0	65,246	50.00
53.00	05300	ANESTHESIOLOGY	2,277	72,668	1,407	0	2,071	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,319	0	3,731	0	181,380	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	19,836	0	36,909	0	152,655	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	8,137	69,072	933	0	12,226	65.00
66.00	06600	PHYSICAL THERAPY	12,916	154,722	726	0	27,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,998	30,499	68	0	6,010	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	65	0	797	68.00
69.00	06900	ELECTROCARDIOLOGY	766	0	84	0	17,371	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	32,441	0	23,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,194	0	1,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	508,746	34,420	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24,817	0	3,431	0	9,304	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	26,733	283,053	9,170	0	57,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	241,231	1,335,231	112,932	508,746	653,447	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,074	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	428	0	78	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	7,438	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
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)	251,171	1,335,231	113,010	508,746	653,447	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part I | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,622,284	0	3,622,284		30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,297,823	0	1,297,823		50.00
53.00	05300	ANESTHESIOLOGY	209,351	0	209,351		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,225,160	0	2,225,160		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	1,817,165	0	1,817,165		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	429,151	0	429,151		65.00
66.00	06600	PHYSICAL THERAPY	1,006,397	0	1,006,397		66.00
67.00	06700	OCCUPATIONAL THERAPY	218,211	0	218,211		67.00
68.00	06800	SPEECH PATHOLOGY	69,853	0	69,853		68.00
69.00	06900	ELECTROCARDIOLOGY	159,433	0	159,433		69.00
70.10	07001	CARDIAC REHAB	0	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	360,573	0	360,573		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,094	0	38,094		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,313,559	0	1,313,559		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,450,959	0	1,450,959		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	2,385,339	0	2,385,339		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,603,352	0	16,603,352		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,564	0	28,564		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	512,757	0	512,757		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	148,717	0	148,717		194.01
194.02	07952	SENIOR CIRCLE	51,308	0	51,308		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	1,565	0	1,565		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	3,893	0	3,893		194.04
194.05	07955	FREE STANDING NURSING HOME	1,931,454	0	1,931,454		194.05
194.06	07956	CLINIC CORPORATION	11,476	0	11,476		194.06
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)	19,293,086	0	19,293,086		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/28/2012 12:10 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	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	3,957	10,930	14,887	14,887	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	79,476	206,074	285,550	2,014	5.00
7.00	00700	OPERATION OF PLANT	0	115,547	319,169	434,716	295	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	825	2,278	3,103	0	8.00
9.00	00900	HOUSEKEEPING	0	6,805	18,799	25,604	220	9.00
10.00	01000	DIETARY	0	21,347	58,966	80,313	0	10.00
11.00	01100	CAFETERIA	0	10,524	29,070	39,594	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,447	31,620	43,067	1,138	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	53	14.00
15.00	01500	PHARMACY	0	0	0	0	363	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,061	30,554	41,615	321	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	41,105	113,544	154,649	1,963	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,040	74,693	101,733	623	50.00
53.00	05300	ANESTHESIOLOGY	0	791	2,184	2,975	613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,691	59,917	81,608	1,031	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	10,607	29,300	39,907	621	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	2,784	7,691	10,475	281	65.00
66.00	06600	PHYSICAL THERAPY	0	11,920	32,926	44,846	629	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,876	5,183	7,059	124	67.00
68.00	06800	SPEECH PATHOLOGY	0	764	2,111	2,875	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,734	10,314	14,048	35	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,174	8,767	11,941	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,353	14,786	20,139	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,179	22,592	30,771	1,161	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	10,744	29,677	40,421	2,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	410,751	1,121,145	1,531,896	14,424	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,020	0	2,020	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	45,278	0	45,278	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,168	5,988	8,156	63	194.01
194.02	07952	SENIOR CIRCLE	0	2,640	0	2,640	13	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	387	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
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	462,857	1,127,133	1,589,990	14,887	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	287,564					5.00
7.00	00700	OPERATION OF PLANT	30,831	465,842				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,178	1,456	6,737			8.00
9.00	00900	HOUSEKEEPING	4,518	12,014	630	42,986		9.00
10.00	01000	DIETARY	25,461	37,685	452	3,581	147,492	10.00
11.00	01100	CAFETERIA	2,367	18,579	0	1,765	0	11.00
13.00	01300	NURSING ADMINISTRATION	18,429	20,208	0	1,920	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,670	0	0	0	0	14.00
15.00	01500	PHARMACY	6,304	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,205	19,527	0	1,856	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,770	72,566	2,786	6,895	16,943	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,147	47,736	888	4,536	0	50.00
53.00	05300	ANESTHESIOLOGY	1,884	1,396	0	133	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,440	38,293	587	3,639	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	23,004	18,726	10	1,779	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	4,772	4,915	0	467	0	65.00
66.00	06600	PHYSICAL THERAPY	10,563	21,043	376	2,000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,460	3,312	0	315	0	67.00
68.00	06800	SPEECH PATHOLOGY	945	1,349	0	128	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,613	6,591	60	626	0	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,198	5,603	0	532	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	497	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,987	9,450	0	898	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,378	14,438	18	1,372	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	28,834	18,966	787	1,802	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	285,455	373,853	6,594	34,244	16,943	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39	3,566	0	339	602	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	79,935	30	7,596	2,049	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,932	3,827	0	364	0	194.01
194.02	07952	SENIOR CIRCLE	138	4,661	42	443	1,320	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	71	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0	126,578	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
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)	287,564	465,842	6,737	42,986	147,492	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	62,305					11.00
13.00	01300	NURSING ADMINISTRATION	5,099	89,861				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	816	0	2,539			14.00
15.00	01500	PHARMACY	1,320	6,010	0	13,997		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,299	0	13	0	74,836	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,159	32,484	431	0	7,178	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,942	10,311	0	0	7,474	50.00
53.00	05300	ANESTHESIOLOGY	565	4,891	32	0	237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,777	0	84	0	20,759	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,920	0	829	0	17,487	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	2,018	4,649	21	0	1,401	65.00
66.00	06600	PHYSICAL THERAPY	3,204	10,413	16	0	3,145	66.00
67.00	06700	OCCUPATIONAL THERAPY	744	2,053	2	0	688	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	0	91	68.00
69.00	06900	ELECTROCARDIOLOGY	190	0	2	0	1,990	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	729	0	2,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	94	0	140	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,997	3,943	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,156	0	77	0	1,066	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,631	19,050	206	0	6,546	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,840	89,861	2,537	13,997	74,836	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	514	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	106	0	2	0	0	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	1,845	0	0	0	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
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)	62,305	89,861	2,539	13,997	74,836	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B Part II | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	345,824	0	345,824		30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	189,390	0	189,390		50.00
53.00	05300	ANESTHESIOLOGY	12,726	0	12,726		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,218	0	180,218		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	107,283	0	107,283		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	28,999	0	28,999		65.00
66.00	06600	PHYSICAL THERAPY	96,235	0	96,235		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,757	0	16,757		67.00
68.00	06800	SPEECH PATHOLOGY	5,389	0	5,389		68.00
69.00	06900	ELECTROCARDIOLOGY	25,155	0	25,155		69.00
70.10	07001	CARDIAC REHAB	0	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,694	0	25,694		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	731	0	731		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,414	0	59,414		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	75,437	0	75,437		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	126,182	0	126,182		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,295,434	0	1,295,434		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,566	0	6,566		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	134,888	0	134,888		192.00
194.00	07950	HOME HEALTH	0	0	0		194.00
194.01	07951	MARKETING	14,856	0	14,856		194.01
194.02	07952	SENIOR CIRCLE	9,365	0	9,365		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	71	0	71		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	128,810	0	128,810		194.05
194.06	07956	CLINIC CORPORATION	0	0	0		194.06
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)	1,589,990	0	1,589,990		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/28/2012 12:10 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	00100	NEW CAP REL COSTS-BLDG & FIXT	122,354					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		107,865				2.00
4.00	00400	EMPLOYEE BENEFITS	1,046	1,046	9,273,630			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,009	19,721	1,254,594	-4,275,013	14,614,833	5.00
7.00	00700	OPERATION OF PLANT	30,544	30,544	183,936	0	1,566,958	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	218	218	0	0	110,673	8.00
9.00	00900	HOUSEKEEPING	1,799	1,799	137,271	0	229,621	9.00
10.00	01000	DIETARY	5,643	5,643	0	0	1,294,000	10.00
11.00	01100	CAFETERIA	2,782	2,782	0	0	120,300	11.00
13.00	01300	NURSING ADMINISTRATION	3,026	3,026	709,128	0	936,626	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	33,129	0	84,888	14.00
15.00	01500	PHARMACY	0	0	226,262	0	320,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,924	2,924	200,026	0	417,017	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,866	10,866	1,223,000	0	1,817,814	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,148	7,148	388,168	0	617,359	50.00
53.00	05300	ANESTHESIOLOGY	209	209	381,879	0	95,736	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,734	5,734	642,560	0	1,394,581	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,804	2,804	386,628	0	1,169,121	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	736	736	175,003	0	242,527	65.00
66.00	06600	PHYSICAL THERAPY	3,151	3,151	392,008	0	536,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	496	77,272	0	125,010	67.00
68.00	06800	SPEECH PATHOLOGY	202	202	0	0	48,003	68.00
69.00	06900	ELECTROCARDIOLOGY	987	987	21,577	0	81,969	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	839	839	0	0	213,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	25,280	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,415	1,415	0	0	558,391	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,162	2,162	723,306	0	1,035,697	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,840	2,840	1,829,528	0	1,465,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	108,580	107,292	8,985,275	-4,275,013	14,507,642	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	534	0	0	0	1,960	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,969	0	0	-74,367	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	573	573	39,425	0	98,208	194.01
194.02	07952	SENIOR CIRCLE	698	0	8,098	0	7,023	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	-3,893	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	240,832	-313,504	0	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	-11,476	0	194.06
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)	462,857	1,127,133	1,440,229		4,275,013	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.782933	10.449479	0.155304		0.292512	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			14,887		287,564	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001605		0.019676	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	69,755					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	218	137,784				8.00
9.00	00900	HOUSEKEEPING	1,799	12,879	67,738			9.00
10.00	01000	DIETARY	5,643	9,239	5,643	120,221		10.00
11.00	01100	CAFETERIA	2,782	0	2,782	0	11,143	11.00
13.00	01300	NURSING ADMINISTRATION	3,026	0	3,026	0	912	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	146	14.00
15.00	01500	PHARMACY	0	0	0	0	236	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,924	0	2,924	0	590	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,866	57,023	10,866	13,810	2,532	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,148	18,164	7,148	0	705	50.00
53.00	05300	ANESTHESIOLOGY	209	0	209	0	101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,734	11,997	5,734	0	1,212	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,804	206	2,804	0	880	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	736	0	736	0	361	65.00
66.00	06600	PHYSICAL THERAPY	3,151	7,690	3,151	0	573	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	0	496	0	133	67.00
68.00	06800	SPEECH PATHOLOGY	202	0	202	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	987	1,218	987	0	34	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	839	0	839	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,415	0	1,415	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,162	367	2,162	0	1,101	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,840	16,088	2,840	0	1,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,981	134,871	53,964	13,810	10,702	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	534	0	534	491	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,969	618	11,969	1,670	0	192.00
194.00	07950	HOME HEALTH	0	0	0	0	0	194.00
194.01	07951	MARKETING	573	0	573	0	92	194.01
194.02	07952	SENIOR CIRCLE	698	851	698	1,076	19	194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	1,444	0	0	0	194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	103,174	330	194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,025,312	149,376	362,984	1,876,609	251,171	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.034650	1.084132	5.358647	15.609661	22.540698	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	465,842	6,737	42,986	147,492	62,305	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.678260	0.048895	0.634592	1.226841	5.591403	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet B-1 | Date/Time Prepared: 11/28/2012 12:10 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	3,382,978					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	681,135				14.00
15.00	01500	PHARMACY	226,262	0	540,061			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,511	0	89,218,773		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,223,000	115,664	0	8,555,257		30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	388,168	0	0	8,908,517		50.00
53.00	05300	ANESTHESIOLOGY	184,113	8,482	0	282,803		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,485	0	24,763,921		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	222,457	0	20,843,173		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	175,003	5,622	0	1,669,308		65.00
66.00	06600	PHYSICAL THERAPY	392,008	4,378	0	3,748,053		66.00
67.00	06700	OCCUPATIONAL THERAPY	77,272	410	0	820,527		67.00
68.00	06800	SPEECH PATHOLOGY	0	392	0	108,855		68.00
69.00	06900	ELECTROCARDIOLOGY	0	509	0	2,371,832		69.00
70.10	07001	CARDIAC REHAB	0	0	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	195,528	0	3,207,716		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,280	0	167,248		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	540,061	4,699,606		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	20,677	0	1,270,278		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	717,152	55,271	0	7,801,679		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0		111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,382,978	680,666	540,061	89,218,773		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	HOME HEALTH	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	469	0	0		194.02
194.03	07953	RED BUD SPECIALTY CLINIC	0	0	0	0		194.03
194.04	07954	WATERLOO SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07955	FREE STANDING NURSING HOME	0	0	0	0		194.05
194.06	07956	CLINIC CORPORATION	0	0	0	0		194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,335,231	113,010	508,746	653,447		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.394691	0.165914	0.942016	0.007324		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,861	2,539	13,997	74,836		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.026563	0.003728	0.025917	0.000839		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/28/2012 12:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,622,284		3,622,284	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,297,823		1,297,823	0	0	50.00
53.00	05300	ANESTHESIOLOGY	209,351		209,351	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,225,160		2,225,160	0	0	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,817,165		1,817,165	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	429,151	0	429,151	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,006,397	0	1,006,397	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,211	0	218,211	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	69,853	0	69,853	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	159,433		159,433	0	0	69.00
70.10	07001	CARDIAC REHAB	0		0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	360,573		360,573	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,094		38,094	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,313,559		1,313,559	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,450,959		1,450,959	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,385,339		2,385,339	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	124,939		124,939		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
200.00		Subtotal (see instructions)	16,728,291	0	16,728,291	0	0	200.00
201.00		Less Observation Beds	124,939		124,939		0	201.00
202.00		Total (see instructions)	16,603,352	0	16,603,352	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/28/2012 12:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,555,257		8,555,257			30.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,722,097	7,186,420	8,908,517	0.145683	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	59,918	222,885	282,803	0.740271	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,026,006	21,921,828	24,947,834	0.089193	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	4,993,753	15,689,088	20,682,841	0.087859	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,334,389	334,919	1,669,308	0.257083	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,742,995	2,005,058	3,748,053	0.268512	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	766,246	54,281	820,527	0.265940	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	77,285	31,570	108,855	0.641707	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	197,866	2,173,966	2,371,832	0.067219	0.000000	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0.000000	0.000000	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,818,688	1,381,633	3,200,321	0.112668	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,941	159,307	167,248	0.227770	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,756,795	1,926,624	4,683,419	0.280470	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,270,278	1,270,278			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	381,248	7,420,431	7,801,679	0.305747	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	44,072	310,277	354,349	0.352587	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	27,484,556	62,088,565	89,573,121			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,484,556	62,088,565	89,573,121			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/28/2012 12:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.10	07001	CARDIAC REHAB	0.000000	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
109.00	10900	PANCREAS ACQUISITION		109.00
110.00	11000	INTESTINAL ACQUISITION		110.00
111.00	11100	ISLET ACQUISITION		111.00
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: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,622,284		3,622,284	0	3,622,284	30.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,297,823		1,297,823	0	1,297,823	50.00
53.00	05300	ANESTHESIOLOGY	209,351		209,351	0	209,351	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,225,160		2,225,160	0	2,225,160	54.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,817,165		1,817,165	0	1,817,165	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	429,151	0	429,151	0	429,151	65.00
66.00	06600	PHYSICAL THERAPY	1,006,397	0	1,006,397	0	1,006,397	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,211	0	218,211	0	218,211	67.00
68.00	06800	SPEECH PATHOLOGY	69,853	0	69,853	0	69,853	68.00
69.00	06900	ELECTROCARDIOLOGY	159,433		159,433	0	159,433	69.00
70.10	07001	CARDIAC REHAB	0		0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	360,573		360,573	0	360,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,094		38,094	0	38,094	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,313,559		1,313,559	0	1,313,559	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,450,959		1,450,959	0	1,450,959	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,385,339		2,385,339	0	2,385,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	124,939		124,939		124,939	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
200.00		Subtotal (see instructions)	16,728,291	0	16,728,291	0	16,728,291	200.00
201.00		Less Observation Beds	124,939		124,939		124,939	201.00
202.00		Total (see instructions)	16,603,352	0	16,603,352	0	16,603,352	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,555,257		8,555,257			30.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,722,097	7,186,420	8,908,517	0.145683	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	59,918	222,885	282,803	0.740271	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,026,006	21,921,828	24,947,834	0.089193	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	4,993,753	15,689,088	20,682,841	0.087859	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,334,389	334,919	1,669,308	0.257083	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,742,995	2,005,058	3,748,053	0.268512	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	766,246	54,281	820,527	0.265940	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	77,285	31,570	108,855	0.641707	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	197,866	2,173,966	2,371,832	0.067219	0.000000	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0.000000	0.000000	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,818,688	1,381,633	3,200,321	0.112668	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,941	159,307	167,248	0.227770	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,756,795	1,926,624	4,683,419	0.280470	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,270,278	1,270,278	1.142237	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	381,248	7,420,431	7,801,679	0.305747	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	44,072	310,277	354,349	0.352587	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	27,484,556	62,088,565	89,573,121			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,484,556	62,088,565	89,573,121			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part I Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.145683		50.00
53.00	05300	ANESTHESIOLOGY	0.740271		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089193		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.087859		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.257083		65.00
66.00	06600	PHYSICAL THERAPY	0.268512		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265940		67.00
68.00	06800	SPEECH PATHOLOGY	0.641707		68.00
69.00	06900	ELECTROCARDIOLOGY	0.067219		69.00
70.10	07001	CARDIAC REHAB	0.000000		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112668		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227770		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.280470		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.142237		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.305747		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352587		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part II | Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,297,823	189,390	1,108,433	0	0	50.00
53.00	05300	ANESTHESIOLOGY	209,351	12,726	196,625	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,225,160	180,218	2,044,942	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,817,165	107,283	1,709,882	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	429,151	28,999	400,152	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,006,397	96,235	910,162	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	218,211	16,757	201,454	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	69,853	5,389	64,464	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	159,433	25,155	134,278	0	0	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	360,573	25,694	334,879	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,094	731	37,363	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,313,559	59,414	1,254,145	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,450,959	75,437	1,375,522	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,385,339	126,182	2,259,157	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	124,939	0	124,939	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
200.00		Subtotal (sum of lines 50 thru 199)	13,106,007	949,610	12,156,397	0	0	200.00
201.00		Less Observation Beds	124,939	0	124,939	0	0	201.00
202.00		Total (line 200 minus line 201)	12,981,068	949,610	12,031,458	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet C Part II Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,297,823	8,908,517	0.145683		50.00
53.00	05300	ANESTHESIOLOGY	209,351	282,803	0.740271		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,225,160	24,947,834	0.089193		54.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000	LABORATORY	1,817,165	20,682,841	0.087859		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	429,151	1,669,308	0.257083		65.00
66.00	06600	PHYSICAL THERAPY	1,006,397	3,748,053	0.268512		66.00
67.00	06700	OCCUPATIONAL THERAPY	218,211	820,527	0.265940		67.00
68.00	06800	SPEECH PATHOLOGY	69,853	108,855	0.641707		68.00
69.00	06900	ELECTROCARDIOLOGY	159,433	2,371,832	0.067219		69.00
70.10	07001	CARDIAC REHAB	0	0	0.000000		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	360,573	3,200,321	0.112668		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,094	167,248	0.227770		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,313,559	4,683,419	0.280470		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,450,959	1,270,278	1.142237		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	0	0	0.000000		90.00
91.00	09100	EMERGENCY	2,385,339	7,801,679	0.305747		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	124,939	354,349	0.352587		92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0.000000		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100	ISLET ACQUISITION	0	0	0.000000		111.00
200.00		Subtotal (sum of lines 50 thru 199)	13,106,007	81,017,864			200.00
201.00		Less Observation Beds	124,939	0			201.00
202.00		Total (line 200 minus line 201)	12,981,068	81,017,864			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part II Date/Time Prepared: 11/28/2012 12:10 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	05000	OPERATING ROOM	189,390	8,908,517	0.021259	629,224	13,377	50.00
53.00	05300	ANESTHESIOLOGY	12,726	282,803	0.045000	24,010	1,080	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,218	24,947,834	0.007224	1,603,814	11,586	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	107,283	20,682,841	0.005187	2,648,761	13,739	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	28,999	1,669,308	0.017372	574,256	9,976	65.00
66.00	06600	PHYSICAL THERAPY	96,235	3,748,053	0.025676	214,359	5,504	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,757	820,527	0.020422	33,463	683	67.00
68.00	06800	SPEECH PATHOLOGY	5,389	108,855	0.049506	13,203	654	68.00
69.00	06900	ELECTROCARDIOLOGY	25,155	2,371,832	0.010606	115,252	1,222	69.00
70.10	07001	CARDIAC REHAB	0	0	0.000000	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,694	3,200,321	0.008029	759,806	6,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	731	167,248	0.004371	1,748	8	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,414	4,683,419	0.012686	1,249,698	15,854	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	75,437	1,270,278	0.059386	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	126,182	7,801,679	0.016174	7,247	117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	354,349	0.000000	1,503	0	92.00
200.00		Total (lines 50-199)	949,610	81,017,864		7,876,344	79,900	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/28/2012 12:10 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	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 11/28/2012 12:10 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	05000	OPERATING ROOM	0	8,908,517	0.000000	0.000000	629,224	50.00
53.00	05300	ANESTHESIOLOGY	0	282,803	0.000000	0.000000	24,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,947,834	0.000000	0.000000	1,603,814	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	20,682,841	0.000000	0.000000	2,648,761	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,669,308	0.000000	0.000000	574,256	65.00
66.00	06600	PHYSICAL THERAPY	0	3,748,053	0.000000	0.000000	214,359	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	820,527	0.000000	0.000000	33,463	67.00
68.00	06800	SPEECH PATHOLOGY	0	108,855	0.000000	0.000000	13,203	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,371,832	0.000000	0.000000	115,252	69.00
70.10	07001	CARDIAC REHAB	0	0	0.000000	0.000000	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,200,321	0.000000	0.000000	759,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	167,248	0.000000	0.000000	1,748	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,683,419	0.000000	0.000000	1,249,698	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,270,278	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	7,801,679	0.000000	0.000000	7,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	354,349	0.000000	0.000000	1,503	92.00
200.00		Total (lines 50-199)	0	81,017,864			7,876,344	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/28/2012 12:10 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	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.10	07001	CARDIAC REHAB	0	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 11/28/2012 12:10 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	05000	OPERATING ROOM	0.145683	0	2,284,549	0		50.00
53.00	05300	ANESTHESIOLOGY	0.740271	0	58,050	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089193	0	7,825,409	0		54.00
57.00	05700	CT SCAN	0.000000	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	06000	LABORATORY	0.087859	0	7,391,840	0		60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0.257083	0	152,983	0		65.00
66.00	06600	PHYSICAL THERAPY	0.268512	0	808,193	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265940	0	11,879	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.641707	0	6,450	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.067219	0	1,742,507	0		69.00
70.10	07001	CARDIAC REHAB	0.000000	0	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112668	0	285,137	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227770	0	32,451	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.280470	0	936,820	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000	CLINIC	0.000000	0	0	0		90.00
91.00	09100	EMERGENCY	0.305747	0	2,385,538	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352587	0	111,904	0		92.00
200.00		Subtotal (see instructions)		0	24,033,710	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	24,033,710	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V Date/Time Prepared: 11/28/2012 12:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs PPS Services (see instructions)	Costs Cost Services Subject To Ded. & Coins. (see instructions)	Costs Cost Services Not Subject To Ded. & Coins. (see instructions)		
			5.00	6.00	7.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	332,820	0		50.00
53.00	05300	ANESTHESIOLOGY	0	42,973	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	697,972	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	649,440	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	39,329	0		65.00
66.00	06600	PHYSICAL THERAPY	0	217,010	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,159	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	4,139	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	117,130	0		69.00
70.10	07001	CARDIAC REHAB	0	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,126	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,391	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	262,750	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	729,371	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	39,456	0		92.00
200.00		Subtotal (see instructions)	0	3,175,066	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,175,066	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141348 | Component CCN: 14Z348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V | Date/Time Prepared: 11/28/2012 12:10 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	05000	OPERATING ROOM	0.145683	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0.740271	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089193	0	0	0		54.00
57.00	05700	CT SCAN	0.000000	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	06000	LABORATORY	0.087859	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0.257083	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.268512	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265940	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.641707	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.067219	0	0	0		69.00
70.10	07001	CARDIAC REHAB	0.000000	0	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112668	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227770	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.280470	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000	CLINIC	0.000000	0	0	0		90.00
91.00	09100	EMERGENCY	0.305747	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352587	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: 141348 | Component CCN: 14Z348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part V | Date/Time Prepared: 11/28/2012 12:10 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	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.10	07001	CARDIAC REHAB	0	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
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 INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I | Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	345,824	174,108	171,716	2,943	58.35	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0.00	42.00
200.00		Total (lines 30-199)	345,824		171,716	2,943		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part I Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
			6.00	7.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	152	8,869		30.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
200.00		Total (lines 30-199)	152	8,869		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part II Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	189,390	8,908,517	0.021259	0	0	50.00
53.00	05300	ANESTHESIOLOGY	12,726	282,803	0.045000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,218	24,947,834	0.007224	0	0	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	107,283	20,682,841	0.005187	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	28,999	1,669,308	0.017372	0	0	65.00
66.00	06600	PHYSICAL THERAPY	96,235	3,748,053	0.025676	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,757	820,527	0.020422	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,389	108,855	0.049506	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,155	2,371,832	0.010606	0	0	69.00
70.10	07001	CARDIAC REHAB	0	0	0.000000	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,694	3,200,321	0.008029	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	731	167,248	0.004371	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,414	4,683,419	0.012686	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	75,437	1,270,278	0.059386	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	126,182	7,801,679	0.016174	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,324	354,349	0.068644	0	0	92.00
200.00		Total (lines 50-199)	973,934	81,017,864		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part III Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,943	0.00	152	0		30.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
200.00		Total (lines 30-199)	2,943		152	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.10	07001	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV | Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,908,517	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	282,803	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,947,834	0.000000	0.000000	0	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	20,682,841	0.000000	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	1,669,308	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,748,053	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	820,527	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	108,855	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,371,832	0.000000	0.000000	0	69.00
70.10	07001	CARDIAC REHAB	0	0	0.000000	0.000000	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,200,321	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	167,248	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,683,419	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,270,278	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	7,801,679	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	354,349	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	81,017,864			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D Part IV Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.10	07001	CARDIAC REHAB	0	0	0		70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/28/2012 12:10 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,302	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,943	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.	97	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,639	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,492	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)	1,492	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	187	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)	188	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,991	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	2,984	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	119.88	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	119.88	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,622,284	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)	22,418	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)	22,537	25.00
26.00	Total swing-bed cost (see instructions)	1,845,978	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,776,306	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	5,278,277	28.00
29.00	Private room charges (excluding swing-bed charges)	177,516	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	5,100,761	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.336531	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,830.06	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,932.84	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,776,306	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)	603.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,201,688	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)	1,201,688	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/28/2012 12:10 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)	1,154,767	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,356,455	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,801,023	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,801,023	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)	207	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	603.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	124,939	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/28/2012 12:10 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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,302	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,943	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)	2,736	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	2,984	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	375	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	152	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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)	3,622,284	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)	1,823,672	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,798,612	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,798,612	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)	611.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	92,895	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)	92,895	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	92,895	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)	8,869	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)	8,869	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	84,026	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	207	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	611.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	126,508	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-1 | Date/Time Prepared: 11/28/2012 12:10 pm

Title XIX | Hospital | PPS

	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	345,824	1,798,612	0.192273	126,508	24,324	90.00
91.00	Nursing School cost	0	1,798,612	0.000000	126,508	0	91.00
92.00	Allied health cost	0	1,798,612	0.000000	126,508	0	92.00
93.00	All other Medical Education	0	1,798,612	0.000000	126,508	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3 | Date/Time Prepared: 11/28/2012 12:10 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,863,461		30.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.145683	629,224	91,667	50.00
53.00	05300	ANESTHESIOLOGY	0.740271	24,010	17,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089193	1,603,814	143,049	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.087859	2,648,761	232,717	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.257083	574,256	147,631	65.00
66.00	06600	PHYSICAL THERAPY	0.268512	214,359	57,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265940	33,463	8,899	67.00
68.00	06800	SPEECH PATHOLOGY	0.641707	13,203	8,472	68.00
69.00	06900	ELECTROCARDIOLOGY	0.067219	115,252	7,747	69.00
70.10	07001	CARDIAC REHAB	0.000000	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112668	759,806	85,606	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227770	1,748	398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.280470	1,249,698	350,503	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.305747	7,247	2,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352587	1,503	530	92.00
200.00		Total (sum of lines 50-94 and 96-98)		7,876,344	1,154,767	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)		7,876,344		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet D-3

Component CCN: 14Z348 | Date/Time Prepared: 11/28/2012 12:10 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,901,172		30.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.145683	55,173	8,038	50.00
53.00	05300	ANESTHESIOLOGY	0.740271	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089193	238,718	21,292	54.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.087859	1,022,572	89,842	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.257083	573,932	147,548	65.00
66.00	06600	PHYSICAL THERAPY	0.268512	1,315,426	353,208	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265940	637,776	169,610	67.00
68.00	06800	SPEECH PATHOLOGY	0.641707	56,435	36,215	68.00
69.00	06900	ELECTROCARDIOLOGY	0.067219	72,749	4,890	69.00
70.10	07001	CARDIAC REHAB	0.000000	0	0	70.10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.112668	581,093	65,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227770	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.280470	988,537	277,255	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.305747	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.352587	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,542,411	1,173,369	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)		5,542,411		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141348	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/28/2012 12:10 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,175,066	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)	3,175,066	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)	3,206,817	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)	590	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,378,614	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)	-172,387	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)	-172,387	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	-172,387	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)	292,795	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	292,795	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	261,288	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	120,408	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)	120,408	40.00
41.00	Interim payments	1,427,390	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)	-1,306,982	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	36,145	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: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2012 12:10 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		1,702,319		1,427,390	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	03/30/2012	94,600		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		94,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,796,919		1,427,390	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		137,881		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,306,982	6.02
7.00	Total Medicare program liability (see instructions)		1,934,800		120,408	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: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2012 12:10 pm

Component CCN: 14Z348 | 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		2,619,143		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	03/30/2012	141,500		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		141,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,760,643		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		124,844		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,885,487		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: 141348 | Component CCN: 14Z348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet E-2 | Date/Time Prepared: 11/28/2012 12:10 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)	1,819,033	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)	1,185,103	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	2,984	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)	3,004,136	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,004,136	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)	3,004,136	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	119,199	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,884,937	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	550	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	2,885,487	0	19.00
20.00	Interim payments	2,760,643	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)	124,844	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	34,124	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141348	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 11/28/2012 12:10 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	2,356,455	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)	2,356,455	4.00
5.00	Primary payer payments	1,556	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,378,464	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)	2,378,464	19.00
20.00	Deductibles (exclude professional component)	464,632	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	1,913,832	22.00
23.00	Coinsurance	19,376	23.00
24.00	Subtotal (line 22 minus line 23)	1,894,456	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	40,344	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	40,344	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,946	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,934,800	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,934,800	30.00
31.00	Interim payments	1,796,919	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)	137,881	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	27,003	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G | Date/Time Prepared: 11/28/2012 12:10 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-455,605	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,258,385	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-323,161	0	0	0	6.00
7.00	Inventory	436,472	0	0	0	7.00
8.00	Prepaid expenses	277,076	0	0	0	8.00
9.00	Other current assets	122,817	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,315,984	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	39,727	0	0	0	12.00
13.00	Land improvements	98,110	0	0	0	13.00
14.00	Accumulated depreciation	-71,469	0	0	0	14.00
15.00	Buildings	1,785,313	0	0	0	15.00
16.00	Accumulated depreciation	-828,294	0	0	0	16.00
17.00	Leasehold improvements	1,781,642	0	0	0	17.00
18.00	Accumulated depreciation	-476,361	0	0	0	18.00
19.00	Fixed equipment	953,106	0	0	0	19.00
20.00	Accumulated depreciation	-272,529	0	0	0	20.00
21.00	Automobiles and trucks	8,478	0	0	0	21.00
22.00	Accumulated depreciation	-3,746	0	0	0	22.00
23.00	Major movable equipment	3,524,852	0	0	0	23.00
24.00	Accumulated depreciation	-2,104,328	0	0	0	24.00
25.00	Minor equipment depreciable	2,506,074	0	0	0	25.00
26.00	Accumulated depreciation	-1,253,502	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)	5,687,073	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,007,479	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,007,479	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,010,536	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,326,022	0	0	0	37.00
38.00	Salaries, wages, and fees payable	864,436	0	0	0	38.00
39.00	Payroll taxes payable	103,265	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	10,086,677	0	0	0	43.00
44.00	Other current liabilities	100,309	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,480,709	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	12,480,709	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-2,470,173				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)	-2,470,173	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,010,536	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 11/28/2012 12:10 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		-3,293,472		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		823,298				2.00
3.00	Total (sum of line 1 and line 2)		-2,470,174		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)		-2,470,174		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)		-2,470,174		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-1 | Date/Time Prepared: 11/28/2012 12:10 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: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/28/2012 12:10 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,278,376		5,278,376	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	3,276,881		3,276,881	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)	8,555,257		8,555,257	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)	8,555,257		8,555,257	17.00
18.00	Ancillary services	18,929,299	0	18,929,299	18.00
19.00	Outpatient services	0	60,818,288	60,818,288	19.00
20.00	RURAL HEALTH CLINIC	0	1,270,278	1,270,278	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFEES	355,083	1,504,480	1,859,563	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	27,839,639	63,593,046	91,432,685	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,441,086		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,441,086		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141348	Period: From 07/01/2011 To 06/30/2012	Worksheet G-3 Date/Time Prepared: 11/28/2012 12:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	91,432,685	1.00
2.00	Less contractual allowances and discounts on patients' accounts	67,462,278	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,970,407	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,441,086	4.00
5.00	Net income from service to patients (line 3 minus line 4)	529,321	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 INCOME	293,977	24.00
25.00	Total other income (sum of lines 6-24)	293,977	25.00
26.00	Total (line 5 plus line 25)	823,298	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	823,298	29.00

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

Provider CCN: 141348 | Component CCN: 148514 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-1 | Date/Time Prepared: 11/28/2012 12:10 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	229,039	0	229,039	81,292	310,331	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	151,812	0	151,812	0	151,812	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	177,912	0	177,912	0	177,912	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	50,746	50,746	0	50,746	9.00
10.00	Subtotal (sum of lines 1-9)	558,763	50,746	609,509	81,292	690,801	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	22,156	22,156	0	22,156	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	22,156	22,156	0	22,156	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	558,763	72,902	631,665	81,292	712,957	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	90,576	98,947	189,523	-9,886	179,637	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	90,576	98,947	189,523	-9,886	179,637	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	649,339	171,849	821,188	71,406	892,594	32.00

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

Provider CCN: 141348 | Component CCN: 148514 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-1 | Date/Time Prepared: 11/28/2012 12:10 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	310,331		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	151,812		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	177,912		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	50,746		9.00
10.00	Subtotal (sum of lines 1-9)	0	690,801		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	22,156		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	22,156		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	712,957		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	179,637		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	179,637		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	892,594		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141348 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-2

Component CCN: 148514 | Date/Time Prepared: 11/28/2012 12:10 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	1.04	3,784	414	431		1.00
2.00	Physician Assistant	0.00	0	207	0		2.00
3.00	Nurse Practitioner	1.78	3,572	207	368		3.00
4.00	Subtotal (sum of lines 1-3)	2.82	7,356		799	7,356	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)	2.82	7,356			7,356	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)					712,957	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)					712,957	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)					179,637	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					558,365	15.00
16.00	Total overhead (sum of lines 14 and 15)					738,002	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					738,002	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					738,002	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,450,959	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3 Date/Time Prepared: 11/28/2012 12:10 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)		1,450,959	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		14,688	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,436,271	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		7,356	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)		7,356	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		195.25	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)	157.40	157.40	8.00
9.00	Rate for Program covered visits (see instructions)	195.25	195.25	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,257	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	831,179	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	831,179	16.00
16.01	Total program charges (see instructions)(from contractor's records)		704,632	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.)		624,577	16.04
16.05	Total program cost (see instructions)		624,577	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		50,458	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		130,834	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		624,577	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		441	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		625,018	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)		625,018	26.00
27.00	Interim payments		478,162	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)		146,856	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		7,498	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141348 | Component CCN: 148514 | Period: From 07/01/2011 To 06/30/2012 | Worksheet M-4 | Date/Time Prepared: 11/28/2012 12:10 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	690,801	690,801	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000500	0.006200	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	345	4,283	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	397	2,192	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	742	6,475	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	712,957	712,957	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	738,002	738,002	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001041	0.009082	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	768	6,703	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,510	13,178	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	17	209	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	88.82	63.05	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	7	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	441	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		14,688	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		441	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5 Date/Time Prepared: 11/28/2012 12:10 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		478,162	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)		478,162	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		146,856	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		625,018	7.00

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