

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure 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: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/11/2012 11:56 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date:	Time:
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 MIDWEST MEDICAL CENTER for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

Title _____

Date _____

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-458,147	-173,583	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	-724,005	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 Skilled Nursing Facility	0	0	0		0	7.00
8.00 Nursing Facility	0	0	0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	118,966		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
12.00 CMHC I	0	0	0		0	12.00
200.00 Total	0	-1,182,152	-54,617	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: 141302		Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 3/11/2012 11:56 am			
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1 MEDICAL CENTER DRIVE	PO Box:							
2.00	City: GALENA	State: IL	Zip Code: 61036-	County: JO DAVIESS					
	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	MIDWEST MEDICAL CENTER	141302	99914	1	02/01/2000	N	O	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF	MIDWEST MEDICAL CENTER	142302	99914		02/01/2000	N	O	N
8.00	Swing Beds - NF						N		N
9.00	Hospital-Based SNF	GALENA STAUSS NURSING HOME	146140	99914		02/17/2010	N	P	N
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC	MIDWEST HEALTH CLINIC	148511	99914		12/09/2010	N	O	N
16.00	Hospital-Based Health Clinic - FQHC						N	N	N
17.00	Hospital-Based (CMHC) 1								
17.10	Hospital-Based (CORF) 1						N	N	N
18.00	Renal Dialysis								
19.00	Other								
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2010	09/30/2011		
21.00	Type of Control (see instructions)					2			
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		
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					2	N		
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0		
						1.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.					2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.					2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	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: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/11/2012 11:56 am		
		Beginning: 1.00	Ending: 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 1.00	XVIII 2.00	XIX 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 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00		62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00		62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	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. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-2
Part I
Date/Time Prepared:
3/11/2012 11:56 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00	
						1.00	2.00	3.00
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00	
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00	
						1.00		
Long Term Care Hospital PPS								
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.					N	80.00	

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				1.00	
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)(i)? 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.			Y	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Y		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		2,000,000	2,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00

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			1.00		2.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N			140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:	Contractor's Number:			141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:	Zip Code:			143.00	
					1.00		
144.00	Are provider based physicians' costs included in worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00	
					1.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N			146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00	
					Part A	Part B	
					1.00	2.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital		Y		Y	155.00	
156.00	Subprovider - IPF		N		N	156.00	
157.00	Subprovider - IRF		N		N	157.00	
158.00	Subprovider - Other		N		N	158.00	
159.00	SNF		N		N	159.00	
160.00	HHA		N		N	160.00	
161.00	CMHC				N	161.00	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							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)						0168.00
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)						0.00169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 3/11/2012 11:56 am
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/10/2012
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		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		
		Y/N	Date	
		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)	N		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)	Y	02/23/2012	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
		UNBILLED CLAIMS WERE ADDED TO OP		

		Part A		
Description		Y/N	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	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		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)	N		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)	Y	02/23/2012	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.	Y		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

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Available		
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	0.00	7.00
8.00 INTENSIVE CARE UNIT					8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		25	9,125	0.00	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	44.00	5	1,825		19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE	46.00	52	18,980		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	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)		82			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

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	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	531	21	632	1.00	
2.00 HMO		2	0		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	858	0	896	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	191	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,389	21	1,719	7.00	
8.00 INTENSIVE CARE UNIT					8.00	
9.00 CORONARY CARE UNIT					9.00	
10.00 BURN INTENSIVE CARE UNIT					10.00	
11.00 SURGICAL INTENSIVE CARE UNIT					11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00	
13.00 NURSERY					13.00	
14.00 Total (see instructions)	0	1,389	21	1,719	14.00	
15.00 CAH visits	0	4,511	0	25,027	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	0	597	0	882	19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE				17,302	21.00	
22.00 HOME HEALTH AGENCY					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
25.10 CMHC - CORF	0	0	0	0	25.10	
26.00 RURAL HEALTH CLINIC	0	711	0	6,944	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	82	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: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Full Time Equivalents			Discharges	Title XVIII	
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V		
	9.00	10.00	11.00	12.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	192	1.00
2.00 HMO					1	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	83.77	0.00	0	192	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	0.00	4.23	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00	44.04	0.00			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	9.77	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	141.81	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

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)	7	248	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)	7	248	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		69	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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

worksheet S-7

Date/Time Prepared:
3/11/2012 11:56 am

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet. Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			1.00
2.00		Y	02/01/2000		2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	12	0	12 18.00
19.00		RHB	13	0	13 19.00
20.00		RHA	6	0	6 20.00
21.00		RMC	208	0	208 21.00
22.00		RMB	45	0	45 22.00
23.00		RMA	78	0	78 23.00
24.00		RLB	24	0	24 24.00
25.00		RLA	27	0	27 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	14	0	14 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	38	0	38 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	21	0	21 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	12	0	12 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	14	0	14 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	61	0	61 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-7

Date/Time Prepared:
3/11/2012 11:56 am

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
69.00	PE2	0	0	0	69.00
70.00	PE1	5	0	5	70.00
71.00	PD2	0	0	0	71.00
72.00	PD1	15	0	15	72.00
73.00	PC2	0	0	0	73.00
74.00	PC1	0	0	0	74.00
75.00	PB2	0	0	0	75.00
76.00	PB1	4	0	4	76.00
77.00	PA2	0	0	0	77.00
78.00	PA1	0	0	0	78.00
199.00	AAA	0	0	0	199.00
200.00	TOTAL	597	0	597	200.00

	CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
	1.00	2.00	

SNF SERVICES
 201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 99914 0 201.00

	Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
	1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	1,117,402	32.06	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	302,526			207.00

1.00 Wage Index Factor 0.8343 1.00

	Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate On/After 10/1	
	1.00	2.00	3.00	4.00	5.00	
3.00	RUX	778.69	778.69	0	778.69	3.00
4.00	RUL	760.00	760.00	0	760.00	4.00
5.00	RVX	696.41	696.41	0	696.41	5.00
6.00	RVL	621.67	621.67	0	621.67	6.00
7.00	RHX	633.56	633.56	0	633.56	7.00
8.00	RHL	561.49	561.49	0	561.49	8.00
9.00	RMX	581.14	581.14	0	581.14	9.00
10.00	RML	533.09	533.09	0	533.09	10.00
11.00	RLX	452.34	452.34	0	452.34	11.00
12.00	RUC	579.81	579.81	0	579.81	12.00
13.00	RUB	579.81	579.81	0	579.81	13.00
14.00	RUA	477.03	477.03	0	477.03	14.00
15.00	RVC	497.54	497.54	0	497.54	15.00
16.00	RVB	426.80	426.80	0	426.80	16.00
17.00	RVA	425.47	425.47	0	425.47	17.00
18.00	RHC	434.69	434.69	0	434.69	18.00
19.00	RHB	389.31	389.31	0	389.31	19.00
20.00	RHA	339.92	339.92	0	339.92	20.00
21.00	RMC	383.61	383.61	0	383.61	21.00
22.00	RMB	356.92	356.92	0	356.92	22.00
23.00	RMA	290.17	290.17	0	290.17	23.00
24.00	RLB	374.87	374.87	0	374.87	24.00
25.00	RLA	233.39	233.39	0	233.39	25.00
26.00	ES3	565.25	565.25	0	565.25	26.00
27.00	ES2	443.79	443.79	0	443.79	27.00
28.00	ES1	397.07	397.07	0	397.07	28.00

	Group	Base Rate	Actual Rate	Days for	Base Rate	
		Prior to 10/1	for Services Prior to 10/1	Services Prior to 10/1	On/After 10/1	
	1.00	2.00	3.00	4.00	5.00	
29.00	HE2	383.72	383.72	0	383.72	29.00
30.00	HE1	319.66	319.66	0	319.66	30.00
31.00	HD2	359.70	359.70	0	359.70	31.00
32.00	HD1	300.97	300.97	0	300.97	32.00
33.00	HC2	339.68	339.68	0	339.68	33.00
34.00	HC1	284.96	284.96	0	284.96	34.00
35.00	HB2	335.68	335.68	0	335.68	35.00
36.00	HB1	282.28	282.28	0	282.28	36.00
37.00	LE2	349.02	349.02	0	349.02	37.00
38.00	LE1	292.97	292.97	0	292.97	38.00
39.00	LD2	335.68	335.68	0	335.68	39.00
40.00	LD1	282.28	282.28	0	282.28	40.00
41.00	LC2	295.63	295.63	0	295.63	41.00
42.00	LC1	250.25	250.25	0	250.25	42.00
43.00	LB2	280.96	280.96	0	280.96	43.00
44.00	LB1	239.57	239.57	0	239.57	44.00
45.00	CE2	311.65	311.65	0	311.65	45.00
46.00	CE1	287.63	287.63	0	287.63	46.00
47.00	CD2	295.63	295.63	0	295.63	47.00
48.00	CD1	271.61	271.61	0	271.61	48.00
49.00	CC2	259.60	259.60	0	259.60	49.00
50.00	CC1	240.91	240.91	0	240.91	50.00
51.00	CB2	240.91	240.91	0	240.91	51.00
52.00	CB1	223.56	223.56	0	223.56	52.00
53.00	CA2	204.88	204.88	0	204.88	53.00
54.00	CA1	191.53	191.53	0	191.53	54.00
55.00	SE3	0.00	0.00	0	0.00	55.00
56.00	SE2	0.00	0.00	0	0.00	56.00
57.00	SE1	0.00	0.00	0	0.00	57.00
58.00	SSC	0.00	0.00	0	0.00	58.00
59.00	SSB	0.00	0.00	0	0.00	59.00
60.00	SSA	0.00	0.00	0	0.00	60.00
61.00	IB2	0.00	0.00	0	0.00	61.00
62.00	IB1	0.00	0.00	0	0.00	62.00
63.00	IA2	0.00	0.00	0	0.00	63.00
64.00	IA1	0.00	0.00	0	0.00	64.00
65.00	BB2	216.89	216.89	0	216.89	65.00
66.00	BB1	207.54	207.54	0	207.54	66.00
67.00	BA2	180.85	180.85	0	180.85	67.00
68.00	BA1	172.84	172.84	0	172.84	68.00
69.00	PE2	287.63	287.63	0	287.63	69.00
70.00	PE1	274.28	274.28	0	274.28	70.00
71.00	PD2	271.61	271.61	0	271.61	71.00
72.00	PD1	258.26	258.26	0	258.26	72.00
73.00	PC2	234.24	234.24	0	234.24	73.00
74.00	PC1	223.56	223.56	0	223.56	74.00
75.00	PB2	199.53	199.53	0	199.53	75.00
76.00	PB1	191.53	191.53	0	191.53	76.00
77.00	PA2	166.17	166.17	0	166.17	77.00
78.00	PA1	159.50	159.50	0	159.50	78.00
199.00	AAA	0.00	0.00	0	0.00	199.00
200.00	TOTAL			0		200.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

worksheet S-7

Date/Time Prepared:
3/11/2012 11:56 am

	Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total	
	6.00	7.00	8.00	
3.00	778.69	0	0	3.00
4.00	760.00	0	0	4.00
5.00	696.41	0	0	5.00
6.00	621.67	0	0	6.00
7.00	633.56	0	0	7.00
8.00	561.49	0	0	8.00
9.00	581.14	0	0	9.00
10.00	533.09	0	0	10.00
11.00	452.34	0	0	11.00
12.00	579.81	0	0	12.00
13.00	579.81	0	0	13.00
14.00	477.03	0	0	14.00
15.00	497.54	0	0	15.00
16.00	426.80	0	0	16.00
17.00	425.47	0	0	17.00
18.00	434.69	0	0	18.00
19.00	389.31	0	0	19.00
20.00	339.92	0	0	20.00
21.00	383.61	0	0	21.00
22.00	356.92	0	0	22.00
23.00	290.17	0	0	23.00
24.00	374.87	0	0	24.00
25.00	233.39	0	0	25.00
26.00	565.25	0	0	26.00
27.00	443.79	0	0	27.00
28.00	397.07	0	0	28.00
29.00	383.72	0	0	29.00
30.00	319.66	0	0	30.00
31.00	359.70	0	0	31.00
32.00	300.97	0	0	32.00
33.00	339.68	0	0	33.00
34.00	284.96	0	0	34.00
35.00	335.68	0	0	35.00
36.00	282.28	0	0	36.00
37.00	349.02	0	0	37.00
38.00	292.97	0	0	38.00
39.00	335.68	0	0	39.00
40.00	282.28	0	0	40.00
41.00	295.63	0	0	41.00
42.00	250.25	0	0	42.00
43.00	280.96	0	0	43.00
44.00	239.57	0	0	44.00
45.00	311.65	0	0	45.00
46.00	287.63	0	0	46.00
47.00	295.63	0	0	47.00
48.00	271.61	0	0	48.00
49.00	259.60	0	0	49.00
50.00	240.91	0	0	50.00
51.00	240.91	0	0	51.00
52.00	223.56	0	0	52.00
53.00	204.88	0	0	53.00
54.00	191.53	0	0	54.00
55.00	0.00	0	0	55.00
56.00	0.00	0	0	56.00
57.00	0.00	0	0	57.00
58.00	0.00	0	0	58.00
59.00	0.00	0	0	59.00
60.00	0.00	0	0	60.00
61.00	0.00	0	0	61.00
62.00	0.00	0	0	62.00
63.00	0.00	0	0	63.00
64.00	0.00	0	0	64.00
65.00	216.89	0	0	65.00
66.00	207.54	0	0	66.00
67.00	180.85	0	0	67.00
68.00	172.84	0	0	68.00
69.00	287.63	0	0	69.00
70.00	274.28	0	0	70.00
71.00	271.61	0	0	71.00
72.00	258.26	0	0	72.00
73.00	234.24	0	0	73.00
74.00	223.56	0	0	74.00
75.00	199.53	0	0	75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

worksheet 5-7

Date/Time Prepared:
3/11/2012 11:56 am

	Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total	
	6.00	7.00	8.00	
76.00	191.53	0	0	76.00
77.00	166.17	0	0	77.00
78.00	159.50	0	0	78.00
199.00	0.00	0	0	199.00
200.00 TOTAL		0	0	200.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141302 Component CCN: 148511	Period: From 10/01/2010 To 09/30/2011	worksheet 5-8 Date/Time Prepared: 3/11/2012 11:56 am	
			Rural Health Clinic (RHC) I	Cost	
			1.00		
Clinic Address and Identification					
1.00	Street	ONE MEDICAL CENTER DRIVE		1.00	
		City	State	Zip Code	
2.00	City, State, Zip Code, County	GALENA	IL	61036	
		1.00	2.00	3.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			1.00	
		Grant Award	Date	0 3.00	
		1.00	2.00		
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0 4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			0 5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0 6.00	
7.00	Appalachian Regional Commission			0 7.00	
8.00	Look-Alikes			0 8.00	
9.00	OTHER (SPECIFY)			0 9.00	
		1.00	2.00		
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0 10.00	
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	Clinic	08:00		17:00	
		1.00	2.00		
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)	0		0	0 15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141302 Component CCN:148511	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/11/2012 11:56 am		
			Rural Health Clinic (RHC) I	Cost		
		County				
		4.00				
2.00	City, State, Zip Code, County	JO DAVIESS			2.00	
		Tuesday		wednesday		
		from	to	from	to	
		5.00	6.00	7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141302 Component CCN:148511	Period: From 10/01/2010 To 09/30/2011	worksheet S-8 Date/Time Prepared: 3/11/2012 11:56 am		
			Rural Health Clinic (RHC) I	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141302 Component CCN:148511	Period: From 10/01/2010 To 09/30/2011	worksheet S-8 Date/Time Prepared: 3/11/2012 11:56 am
			Rural Health Clinic (RHC) I	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic	08:00	12:00	11.00

				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)			0.957570	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			1,332,267	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			3,655,374	6.00
7.00	Medicaid cost (line 1 times line 6)			3,500,276	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)			2,168,009	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,168,009	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	172,938	0	172,938	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	165,600	0	165,600	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	165,600	0	165,600	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			487,147	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			17,416	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			469,731	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			449,800	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			615,400	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,783,409	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		1,755,181	1,755,181	-1,643,773	111,408	1.00
1.01 NEW CAP REL COSTS-ALU BLDG		0	0	114,344	114,344	1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL		0	0	4,290,789	4,290,789	1.02
1.03 NEW CAP REL COSTS-2007 MOB		0	0	0	0	1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP		907,797	907,797	-749,759	158,038	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO		0	0	1,160,634	1,160,634	2.01
3.00 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	0	1,181,699	1,181,699	-54,689	1,127,010	4.00
5.01 ADMITTING	170,353	14,462	184,815	0	184,815	5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	476,950	981,142	1,458,092	-210,193	1,247,899	5.02
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	45,309	628,291	673,600	-130,188	543,412	7.00
7.01 OPERATION OF PLANT-SCC	65,038	75,914	140,952	130,188	271,140	7.01
8.00 LAUNDRY & LINEN SERVICE	0	90,308	90,308	-37,820	52,488	8.00
8.01 LAUNDRY & LINEN SERVICE-SCC	0	0	0	37,820	37,820	8.01
9.00 HOUSEKEEPING	102,061	1,050	103,111	0	103,111	9.00
9.01 HOUSEKEEPING-SCC	61,116	0	61,116	0	61,116	9.01
10.00 DIETARY	131,109	103,809	234,918	0	234,918	10.00
10.01 DIETARY-SCC	191,719	183,589	375,308	36,684	411,992	10.01
11.00 CAFETERIA	0	0	0	0	0	11.00
11.01 CAFETERIA-SCC	0	0	0	0	0	11.01
13.00 NURSING ADMINISTRATION	137,632	591	138,223	0	138,223	13.00
15.00 PHARMACY	0	0	0	141,782	141,782	15.00
16.00 MEDICAL RECORDS & LIBRARY	95,039	3,751	98,790	0	98,790	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	422,275	81,037	503,312	24,114	527,426	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	0	0	0	91,286	91,286	44.00
46.00 OTHER LONG TERM CARE	1,117,402	152,633	1,270,035	61,256	1,331,291	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	63,015	156,117	219,132	4,738	223,870	50.00
53.00 ANESTHESIOLOGY	0	48,857	48,857	9,219	58,076	53.00
54.00 RADIOLOGY-DIAGNOSTIC	253,056	640,292	893,348	0	893,348	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	222,226	271,252	493,478	0	493,478	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	30,551	30,551	0	30,551	64.00
65.00 RESPIRATORY THERAPY	28,860	24,479	53,339	0	53,339	65.00
66.00 PHYSICAL THERAPY	456,520	74,809	531,329	-26,834	504,495	66.00
67.00 OCCUPATIONAL THERAPY	0	55,305	55,305	9,938	65,243	67.00
68.00 SPEECH PATHOLOGY	0	12,077	12,077	0	12,077	68.00
69.00 ELECTROCARDIOLOGY	5,060	0	5,060	0	5,060	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	62,584	83,510	146,094	0	146,094	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	325,710	325,710	-128,562	197,148	73.00
76.00 SLEEP LAB	0	49	49	-49	0	76.00
76.01 PAIN CLINIC	0	9,219	9,219	-9,219	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	14,352	14,352	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	962,373	962,373	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	993,188	136,182	1,129,370	-951,229	178,141	90.00
91.00 EMERGENCY	262,575	1,166,083	1,428,658	1,170	1,429,828	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	3,070,238	3,070,238	-3,070,238	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5,363,087	12,265,984	17,629,071	78,134	17,707,205	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	83,947	83,947	-56,125	27,822	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	194,353	126,150	320,503	1,486	321,989	194.01
194.02 ADULT DAY CARE	104,399	72,381	176,780	-40,391	136,389	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 IDLE SPACE	0	0	0	0	0	194.04
194.05 COMMUNITY FITNESS CENTER	0	0	0	16,896	16,896	194.05
200.00 TOTAL (SUM OF LINES 118-199)	5,661,839	12,548,462	18,210,301	0	18,210,301	200.00

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	111,408	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	114,344	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	-156,514	4,134,275	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-1,814	156,224	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	-30,884	1,129,750	2.01
3.00	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	0	1,127,010	4.00
5.01	ADMITTING	0	184,815	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL	-39,324	1,208,575	5.02
6.00	MAINTENANCE & REPAIRS	0	0	6.00
7.00	OPERATION OF PLANT	-5,493	537,919	7.00
7.01	OPERATION OF PLANT-SCC	0	271,140	7.01
8.00	LAUNDRY & LINEN SERVICE	0	52,488	8.00
8.01	LAUNDRY & LINEN SERVICE-SCC	0	37,820	8.01
9.00	HOUSEKEEPING	0	103,111	9.00
9.01	HOUSEKEEPING-SCC	0	61,116	9.01
10.00	DIETARY	0	234,918	10.00
10.01	DIETARY-SCC	-103,023	308,969	10.01
11.00	CAFETERIA	-47,799	-47,799	11.00
11.01	CAFETERIA-SCC	-60,741	-60,741	11.01
13.00	NURSING ADMINISTRATION	0	138,223	13.00
15.00	PHARMACY	0	141,782	15.00
16.00	MEDICAL RECORDS & LIBRARY	-2,221	96,569	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-4,530	522,896	30.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
44.00	SKILLED NURSING FACILITY	0	91,286	44.00
46.00	OTHER LONG TERM CARE	-31,464	1,299,827	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-69,075	154,795	50.00
53.00	ANESTHESIOLOGY	0	58,076	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-197,471	695,877	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	493,478	60.00
60.01	BLOOD LABORATORY	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	30,551	64.00
65.00	RESPIRATORY THERAPY	0	53,339	65.00
66.00	PHYSICAL THERAPY	0	504,495	66.00
67.00	OCCUPATIONAL THERAPY	0	65,243	67.00
68.00	SPEECH PATHOLOGY	0	12,077	68.00
69.00	ELECTROCARDIOLOGY	0	5,060	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	146,094	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	197,148	73.00
76.00	SLEEP LAB	0	0	76.00
76.01	PAIN CLINIC	0	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0	14,352	76.02
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	962,373	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	-111,433	66,708	90.00
91.00	EMERGENCY	-227,475	1,202,353	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,089,261	16,617,944	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	27,822	192.00
192.01	MIDWEST MEDICAL CLINIC	0	0	192.01
194.00	OTHER NONREIMBURSABLE	0	0	194.00
194.01	ASSISTED LIVING UNITS	0	321,989	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
194.02	ADULT DAY CARE	0	136,389	194.02
194.03	GRANT FUNDED PROGRAMS	0	0	194.03
194.04	IDLE SPACE	0	0	194.04
194.05	COMMUNITY FITNESS CENTER	0	16,896	194.05
200.00	TOTAL (SUM OF LINES 118-199)	-1,089,261	17,121,040	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS ADC AND ALU DIETARY EXPENSE					
1.00	DIETARY-SCC	10.01	0	36,684	1.00
	TOTALS		0	36,684	
C - RECLASS ASSISTED LIVING BUILDING DEP					
1.00	NEW CAP REL COSTS-ALU BLDG	1.01	0	112,041	1.00
	TOTALS		0	112,041	
D - RECLASS PT/MOB SPACE DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	12,738	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	43,387	2.00
	TOTALS		0	56,125	
E - RECLASS NURSING HOME ADMIN AND GEN					
1.00	SKILLED NURSING FACILITY	44.00	0	17,113	1.00
2.00	OTHER LONG TERM CARE	46.00	0	173,034	2.00
	TOTALS		0	190,147	
F - RECLASS PHARMACIST EXPENSE					
1.00	PHARMACY	15.00	0	141,782	1.00
	TOTALS		0	141,782	
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT					
1.00	ADULTS & PEDIATRICS	30.00	8,436	844	1.00
	TOTALS		8,436	844	
H - RECLASS NEW HOSPITAL DEPRECIATION					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	1,567,932	1.00
	TOTALS		0	1,567,932	
I - RECLASS NEW HOSPITAL BOND AMORTIZATN					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	24,071	1.00
	TOTALS		0	24,071	
J - RECLASS NEW HOSPITAL MME DEPRECIATN					
1.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	752,832	1.00
	TOTALS		0	752,832	
K - RECLASS INTEREST EXPENSE - NEW HOSP					
1.00	NEW CAP REL COSTS-2007 HOSPITAL	1.02	0	2,667,372	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	0	402,866	2.00
	TOTALS		0	3,070,238	
L - RECLASS SENIOR CARE CAMPUS UTILITIES					
1.00	OPERATION OF PLANT-SCC	7.01	0	130,188	1.00
	TOTALS		0	130,188	
M - RECLASS PHYSICIAN IP ROUND TIME					
1.00	ADULTS & PEDIATRICS	30.00	4,860	634	1.00
	TOTALS		4,860	634	
P - RECLASS PHYSICIAN BENEFITS					
1.00	CLINIC	90.00	0	4,855	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	20,826	2.00
3.00	CLINIC	90.00	0	5,484	3.00
4.00	RURAL HEALTH CLINIC	88.00	0	23,524	4.00
	TOTALS		0	54,689	
S - RECLASS CHIEF MED DIRECTOR FEES					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	4,485	1.00
	TOTALS		0	4,485	
T - RECLASS RHC COSTS AFTER CERTIFICATN					
1.00	RURAL HEALTH CLINIC	88.00	838,576	112,043	1.00
	TOTALS		838,576	112,043	
U - RECLASS COMMUNITY FITNESS CTR USE					
1.00	COMMUNITY FITNESS CENTER	194.05	9,356	7,540	1.00
2.00	OCCUPATIONAL THERAPY	67.00	8,202	1,736	2.00
	TOTALS		17,558	9,276	
V - RECLASS MEDICARE CERTIFIED SNF UNIT					
1.00	SKILLED NURSING FACILITY	44.00	54,199	17,537	1.00
	TOTALS		54,199	17,537	
X - RECLASS SURGEON FEES					
1.00	RURAL HEALTH CLINIC	88.00	0	40,262	1.00
2.00	OPERATING ROOM	50.00	0	4,738	2.00
	TOTALS		0	45,000	
Y - RECLASS PROPERTY INSURANCE EXP					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	45,872	1.00
	TOTALS		0	45,872	

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
Z - RECLASS CMO CONTRACTED FEES FROM SAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.02	0	20,614	1.00
	TOTALS			0	20,614	
AA - RECLASS CLINIC MGR TIME TO HOSP/NH						
1.00	OTHER LONG TERM CARE		46.00	3,826	0	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL		5.02	5,261	0	2.00
	TOTALS			9,087	0	
BB - RECLASS SR CARE ADMINISTRATOR TIME						
1.00	SKILLED NURSING FACILITY		44.00	2,437	0	1.00
2.00	ASSISTED LIVING UNITS		194.01	9,570	0	2.00
3.00	ADULT DAY CARE		194.02	4,289	0	3.00
	TOTALS			16,296	0	
CC - RECLASS ANESTHESIA COSTS AND SUPPLIE						
1.00	ANESTHESIOLOGY		53.00	0	9,219	1.00
2.00	CLINIC		90.00	0	49	2.00
	TOTALS			0	9,268	
DD - RECLASS NURSE PRACTITIONER MGMT TIME						
1.00	ADULTS & PEDIATRICS		30.00	8,676	664	1.00
2.00	EMERGENCY		91.00	5,253	402	2.00
	TOTALS			13,929	1,066	
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY						
1.00	LAUNDRY & LINEN SERVICE-SCC		8.01	0	37,820	1.00
	TOTALS			0	37,820	
FF - RECLASS EXPENSES TO MATCH REVENUES						
1.00	DRUGS CHARGED TO PATIENTS		73.00	0	13,220	1.00
2.00	SNF PHYSICAL THERAPY - SCC THERAPY		76.02	13,582	770	2.00
	TOTALS			13,582	13,990	
GG - RECLASS OUTSOURCE BILLING FEES						
1.00	OTHER ADMINISTRATIVE AND GENERAL		5.02	0	16,080	1.00
2.00			0.00	0	0	2.00
	TOTALS			0	16,080	
500.00	Grand Total: Increases			976,523	6,471,258	500.00

		Decreases			wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other			
6.00	7.00	8.00	9.00	10.00		
A - RECLASS ADC AND ALU DIETARY EXPENSE						
1.00	ADULT DAY CARE	194.02	0	36,684	0	1.00
	TOTALS		0	36,684		
C - RECLASS ASSISTED LIVING BUILDING DEP						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	112,041	9	1.00
	TOTALS		0	112,041		
D - RECLASS PT/MOB SPACE DEPRECIATION						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,738	9	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	43,387	9	2.00
	TOTALS		0	56,125		
E - RECLASS NURSING HOME ADMIN AND GEN						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	190,147	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	190,147		
F - RECLASS PHARMACIST EXPENSE						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	141,782	0	1.00
	TOTALS		0	141,782		
G - RECLASS PHYSICIAN HOSPITAL MED DIRCT						
1.00	CLINIC	90.00	8,436	844	0	1.00
	TOTALS		8,436	844		
H - RECLASS NEW HOSPITAL DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,567,932	9	1.00
	TOTALS		0	1,567,932		
I - RECLASS NEW HOSPITAL BOND AMORTIZATN						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	24,071	9	1.00
	TOTALS		0	24,071		
J - RECLASS NEW HOSPITAL MME DEPRECIATN						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	752,832	9	1.00
	TOTALS		0	752,832		
K - RECLASS INTEREST EXPENSE - NEW HOSP						
1.00	INTEREST EXPENSE	113.00	0	3,070,238	11	1.00
2.00		0.00	0	0	11	2.00
	TOTALS		0	3,070,238		
L - RECLASS SENIOR CARE CAMPUS UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	130,188	0	1.00
	TOTALS		0	130,188		
M - RECLASS PHYSICIAN IP ROUND TIME						
1.00	RURAL HEALTH CLINIC	88.00	4,860	634	0	1.00
	TOTALS		4,860	634		
P - RECLASS PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	0	54,689	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	54,689		
S - RECLASS CHIEF MED DIRECTOR FEES						
1.00	EMERGENCY	91.00	0	4,485	0	1.00
	TOTALS		0	4,485		
T - RECLASS RHC COSTS AFTER CERTIFICATN						
1.00	CLINIC	90.00	838,576	112,043	0	1.00
	TOTALS		838,576	112,043		
U - RECLASS COMMUNITY FITNESS CTR USE						
1.00	PHYSICAL THERAPY	66.00	17,558	9,276	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		17,558	9,276		
V - RECLASS MEDICARE CERTIFIED SNF UNIT						
1.00	OTHER LONG TERM CARE	46.00	54,199	17,537	0	1.00
	TOTALS		54,199	17,537		
X - RECLASS SURGEON FEES						
1.00	RURAL HEALTH CLINIC	88.00	45,000	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		45,000	0		
Y - RECLASS PROPERTY INSURANCE EXP						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	45,872	12	1.00
	TOTALS		0	45,872		

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
Z - RECLASS CMO CONTRACTED FEES FROM SAL							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	20,614	0	0		1.00
	TOTALS		20,614	0			
AA - RECLASS CLINIC MGR TIME TO HOSP/NH							
1.00	RURAL HEALTH CLINIC	88.00	7,369	0	0		1.00
2.00	CLINIC	90.00	1,718	0	0		2.00
	TOTALS		9,087	0			
BB - RECLASS SR CARE ADMINISTRATOR TIME							
1.00	OTHER LONG TERM CARE	46.00	16,296	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		16,296	0			
CC - RECLASS ANESTHESIA COSTS AND SUPPLIE							
1.00	PAIN CLINIC	76.01	0	9,219	0		1.00
2.00	SLEEP LAB	76.00	0	49	0		2.00
	TOTALS		0	9,268			
DD - RECLASS NURSE PRACTITIONER MGMT TIME							
1.00	RURAL HEALTH CLINIC	88.00	13,929	1,066	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		13,929	1,066			
EE - RECLASS SENIOR CARE CAMPUS LAUNDRY							
1.00	LAUNDRY & LINEN SERVICE	8.00	0	37,820	0		1.00
	TOTALS		0	37,820			
FF - RECLASS EXPENSES TO MATCH REVENUES							
1.00	OTHER LONG TERM CARE	46.00	13,582	13,990	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		13,582	13,990			
GG - RECLASS OUTSOURCE BILLING FEES							
1.00	ASSISTED LIVING UNITS	194.01	0	8,084	0		1.00
2.00	ADULT DAY CARE	194.02	0	7,996	0		2.00
	TOTALS		0	16,080			
500.00	Grand Total: Decreases		1,042,137	6,405,644			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
3/11/2012 11:56 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	559,916	0	0	0	1.00
2.00	Land Improvements	3,683,380	25,136	0	25,136	2.00
3.00	Buildings and Fixtures	38,900,433	77,911	0	77,911	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	9,035,779	37,896	0	37,896	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,179,508	140,943	0	140,943	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,179,508	140,943	0	140,943	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,755,181	0	0	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	0	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	907,797	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	2,662,978	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL 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	4,673,706	0	4,673,706	0.090375	4,146
1.01	NEW CAP REL COSTS-ALU BLDG	2,596,650	0	2,596,650	0.050211	2,303
1.02	NEW CAP REL COSTS-2007 HOSPITAL	35,416,505	0	35,416,505	0.684841	31,414
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0.000000	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,463,848	0	3,463,848	0.066980	3,073
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	5,564,157	0	5,564,157	0.107593	4,936
3.00	Total (sum of lines 1-2)	51,714,866	0	51,714,866	1.000000	45,872

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
3/11/2012 11:56 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	559,916	0		1.00		
2.00	Land Improvements	3,708,516	0		2.00		
3.00	Buildings and Fixtures	38,978,344	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	9,028,005	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	52,274,781	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	52,274,781	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,755,181		1.00		
1.01	NEW CAP REL COSTS-ALU BLDG	0	0		1.01		
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0		1.02		
1.03	NEW CAP REL COSTS-2007 MOB	0	0		1.03		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	907,797		2.00		
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0		2.01		
3.00	Total (sum of lines 1-2)	0	2,662,978		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL 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	4,146	107,262	0	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	0	2,303	112,041	0	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	0	0	31,414	1,592,003	0	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	3,073	153,151	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	0	4,936	744,644	0	2.01
3.00	Total (sum of lines 1-2)	0	0	45,872	2,709,101	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	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	4,146	0	0	111,408	1.00
1.01	NEW CAP REL COSTS-ALU BLDG	0	2,303	0	0	114,344	1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL	2,510,858	31,414	0	0	4,134,275	1.02
1.03	NEW CAP REL COSTS-2007 MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	3,073	0	0	156,224	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	380,170	4,936	0	0	1,129,750	2.01
3.00	Total (sum of lines 1-2)	2,891,028	45,872	0	0	5,646,001	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01 Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)			0	NEW CAP REL COSTS-ALU BLDG	1.01	1.01
1.02 Investment income - NEW CAP REL COSTS-2007 HOSPITAL (chapter 2)			0	NEW CAP REL COSTS-2007 HOSPITAL	1.02	1.02
1.03 Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)			0	NEW CAP REL COSTS-2007 MOB	1.03	1.03
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
2.01 Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	2.01
3.00 Investment income - other (chapter 2)	B	-4,829		NEW CAP REL COSTS-2007 HOSPITAL	1.02	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)	B	-5,493		OPERATION OF PLANT	7.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	7.00
8.00 Television and radio service (chapter 21)		0			0.00	8.00
9.00 Parking lot (chapter 21)		0			0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-609,984				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-47,799		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		0			0.00	17.00
18.00 Sale of medical records and abstracts	B	-2,221		MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines		0			0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01 Depreciation - NEW CAP REL COSTS-ALU BLDG			0	NEW CAP REL COSTS-ALU BLDG	1.01	26.01
26.02 Depreciation - NEW CAP REL COSTS-2007 HOSPITAL			0	NEW CAP REL COSTS-2007 HOSPITAL	1.02	26.02
26.03 Depreciation - NEW CAP REL COSTS-2007 MOB			0	NEW CAP REL COSTS-2007 MOB	1.03	26.03
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
27.01 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO			0	NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	27.01
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		OCCUPATIONAL THERAPY	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	33.00
33.01 INVESTMENT INCOME	B	-729		NEW CAP REL COSTS-MVBLE EQUIP NEW HO	2.01	33.01
33.05 DISALLOW PT BUYOUT AMORTIZATION EXP	A	-6,240		NEW CAP REL COSTS-2007 HOSPITAL	1.02	33.05

ADJUSTMENTS TO EXPENSES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		Line #	
			Cost Center			
			1.00	2.00		
33.06 PART B BILLING COSTS	A	-18,127	OTHER ADMINISTRATIVE AND GENERAL		5.02	33.06
33.07 PATIENT PHONE DEPRECIATION	A	-1,814	NEW CAP REL COSTS-MVBLE EQUIP		2.00	33.07
33.08 PATIENT TELEVISION DEPRECIATION	A	-8,188	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01	33.08
33.09 MARKETING EXPENSES - NONALLOW	A	-1,885	OTHER ADMINISTRATIVE AND GENERAL		5.02	33.09
34.00 LOBBYING EXPENSE ON DUES PAID	A	-6,105	OTHER ADMINISTRATIVE AND GENERAL		5.02	34.00
35.00 COMMUNITY GRANTS / DONATIONS / PROM	A	-13,207	OTHER ADMINISTRATIVE AND GENERAL		5.02	35.00
36.00 NH BED ASSESSMENT	A	-31,464	OTHER LONG TERM CARE		46.00	36.00
37.00 UNNECESSARY BORROWING ADJ - NEW HOSP	A	-145,445	NEW CAP REL COSTS-2007 HOSPITAL		1.02	37.00
38.00 UNNECESSARY BORROWING ADJ - NEW MME	A	-21,967	NEW CAP REL COSTS-MVBLE EQUIP NEW HO		2.01	38.00
40.00 SENIOR CARE CAMPUS CAFETERIA	B	-60,741	CAFETERIA-SCC		11.01	40.00
41.00 OFFSET INTERNAL ALLOCATION FOR ADC/A	B	-103,023	DIETARY-SCC		10.01	41.00
42.00		0			0.00	42.00
43.00		0			0.00	43.00
44.00		0			0.00	44.00
45.00		0			0.00	45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-1,089,261				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		wkst. A-7 Ref,	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
1.01	Investment income - NEW CAP REL COSTS-ALU BLDG (chapter 2)	0	1.01
1.02	Investment income - NEW CAP REL COSTS-2007 HOSPITAL (chapter 2)	0	1.02
1.03	Investment income - NEW CAP REL COSTS-2007 MOB (chapter 2)	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP NEW HO (chapter 2)	0	2.01
3.00	Investment income - other (chapter 2)	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-ALU BLDG	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-2007 HOSPITAL	0	26.02
26.03	Depreciation - NEW CAP REL COSTS-2007 MOB	0	26.03
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP NEW HO	0	27.01
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)	0	33.00
33.01	INVESTMENT INCOME	11	33.01
33.05	DISALLOW PT BUYOUT AMORTIZATION EXP	11	33.05
33.06	PART B BILLING COSTS	0	33.06
33.07	PATIENT PHONE DEPRECIATION	9	33.07
33.08	PATIENT TELEVISION DEPRECIATION	9	33.08
33.09	MARKETING EXPENSES - NONALLOW	0	33.09
34.00	LOBBYING EXPENSE ON DUES PAID	0	34.00
35.00	COMMUNITY GRANTS / DONATIONS / PROM	0	35.00
36.00	NH BED ASSESSMENT	0	36.00
37.00	UNNECESSARY BORROWING ADJ - NEW HOSP	11	37.00
38.00	UNNECESSARY BORROWING ADJ - NEW MME	11	38.00
40.00	SENIOR CARE CAMPUS CAFETERIA	0	40.00
41.00	OFFSET INTERNAL ALLOCATION FOR ADC/A	0	41.00

Provider CCN: 141302

Period:
 From 10/01/2010
 To 09/30/2011

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Wkst. A-7	Ref.	
		5.00		
42.00			0	42.00
43.00			0	43.00
44.00			0	44.00
45.00			0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	ER PHYSICIANS	1,058,515	227,475	1.00
2.00	90.00	PROVIDER BASED CLINIC PROVIDERS	111,434	111,433	2.00
3.00	60.00	LAB MD MEDICAL DIRECTOR	13,477	0	3.00
4.00	54.00	RADIOLOGIST	197,472	197,471	4.00
5.00	30.00	HOSPITAL IP ROUNDS	4,531	4,530	5.00
6.00	50.00	PLASTIC SURGEON FEES	64,339	64,338	6.00
7.00	50.00	SURGEON FEES	4,738	4,737	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	1,454,506	609,984	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
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	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	831,040	0	0	0	0	1.00
2.00	1	0	0	0	0	2.00
3.00	13,477	0	0	0	0	3.00
4.00	1	0	0	0	0	4.00
5.00	1	0	0	0	0	5.00
6.00	1	0	0	0	0	6.00
7.00	1	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	844,522					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
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	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: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	227,475	1.00
2.00	0	111,433	2.00
3.00	0	0	3.00
4.00	0	197,471	4.00
5.00	0	4,530	5.00
6.00	0	64,338	6.00
7.00	0	4,737	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	609,984	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141302		Period: From 10/01/2010 To 09/30/2011		Worksheet A-8-3 Par Date/Time Prepared: 3/11/2012 11:56 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					144	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					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
						1.00	
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	574.70	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	71.42	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)	35.71	35.71	0.00			11.00
12.00	Number of travel hours (provider site)	0	427	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)					41,045	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					41,045	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)					41,045	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)					71.42	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					55,708	22.00
23.00	Total salary equivalency (see instructions)					55,708	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)					5,142	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)					5,142	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)					792	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,934	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)					30,496	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)					30,496	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)					0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141302		Period: From 10/01/2010 To 09/30/2011		Worksheet A-8-3 Par	
				Occupational Therapy		Date/Time Prepared: 3/11/2012 11:56 am	
						Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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	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)	71.42	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)					55,708	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					55,708	63.00
64.00	Total cost of outside supplier services (from your records)					55,305	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					5,142	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					792	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					5,934	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					792	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					30,496	101.01
101.02	Line 34 = sum of lines 27 and 31					31,288	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					30,496	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					30,496	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 3/11/2012 11:56 am			
		Speech Pathology		Cost			
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)			40	1.00		
2.00	Line 1 multiplied by 15 hours per week			600	2.00		
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			68	3.00		
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00		
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00		
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00		
7.00	Standard travel expense rate			0.51	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	272.15	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	65.91	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)	32.96	32.96	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	2,172	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)			17,937	15.00		
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00		
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			17,937	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)			17,937	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)			65.91	21.00		
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			39,546	22.00		
23.00	Total salary equivalency (see instructions)			39,546	23.00		
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)			2,241	24.00		
25.00	Assistants (line 4 times column 3, line 11)			0	25.00		
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			2,241	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)			35	27.00		
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			2,276	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)			0	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: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 3/11/2012 11:56 am
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	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
	1.00	2.00	3.00
		Trainees	Total
		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	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	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)	65.91	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)	39,546	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	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)	39,546	63.00
64.00	Total cost of outside supplier services (from your records)	12,658	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00

LINE 33 CALCULATION

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	2,241	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	35	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	2,276	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	35	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	35	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 Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS			NEW 2007 MOB
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL	
		1.00	1.01	1.02	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	111,408	111,408			1.00
1.01 NEW CAP REL COSTS-ALU BLDG	114,344	0	114,344		1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL	4,134,275	0	0	4,134,275	1.02
1.03 NEW CAP REL COSTS-2007 MOB	0	0	0	0	1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP	156,224				2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	1,129,750				2.01
4.00 EMPLOYEE BENEFITS	1,127,010	0	0	0	4.00
5.01 ADMITTING	184,815	0	0	59,753	5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	1,208,575	17,827	34,378	388,279	5.02
6.00 MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 OPERATION OF PLANT	537,919	0	0	278,086	7.00
7.01 OPERATION OF PLANT-SCC	271,140	4,245	0	0	7.01
8.00 LAUNDRY & LINEN SERVICE	52,488	0	0	28,101	8.00
8.01 LAUNDRY & LINEN SERVICE-SCC	37,820	425	0	0	8.01
9.00 HOUSEKEEPING	103,111	0	0	21,312	9.00
9.01 HOUSEKEEPING-SCC	61,116	807	0	0	9.01
10.00 DIETARY	234,918	0	0	99,536	10.00
10.01 DIETARY-SCC	308,969	3,138	0	0	10.01
11.00 CAFETERIA	-47,799	0	0	153,528	11.00
11.01 CAFETERIA-SCC	-60,741	0	0	0	11.01
13.00 NURSING ADMINISTRATION	138,223	1,407	0	10,104	13.00
15.00 PHARMACY	141,782	0	0	61,016	15.00
16.00 MEDICAL RECORDS & LIBRARY	96,569	0	0	54,228	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	522,896	0	0	706,465	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	91,286	3,683	0	0	44.00
46.00 OTHER LONG TERM CARE	1,299,827	38,310	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	154,795	0	0	424,984	50.00
53.00 ANESTHESIOLOGY	58,076	0	0	4,262	53.00
54.00 RADIOLOGY-DIAGNOSTIC	695,877	0	0	286,611	54.00
57.00 CT SCAN	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	493,478	0	0	84,934	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	30,551	0	0	0	64.00
65.00 RESPIRATORY THERAPY	53,339	0	0	14,840	65.00
66.00 PHYSICAL THERAPY	504,495	0	0	367,519	66.00
67.00 OCCUPATIONAL THERAPY	65,243	0	0	21,312	67.00
68.00 SPEECH PATHOLOGY	12,077	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	5,060	0	0	9,314	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	146,094	0	0	53,833	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	197,148	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	14,352	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	962,373	0	0	421,431	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 CLINIC	66,708	0	0	98,195	90.00
91.00 EMERGENCY	1,202,353	0	0	428,062	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,617,944	69,842	34,378	4,075,705	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	23,444	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS			NEW 2007 MOB	
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL		
		1.00	1.01	1.02		
192.00 PHYSICIANS' PRIVATE OFFICES	27,822	0	0	0	0	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	321,989	0	73,979	0	0	194.01
194.02 ADULT DAY CARE	136,389	0	5,987	0	0	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 IDLE SPACE	0	41,566	0	0	0	194.04
194.05 COMMUNITY FITNESS CENTER	16,896	0	0	35,126	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	17,121,040	111,408	114,344	4,134,275	0	202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMITTING	Subtotal	
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO				
	2.00	2.01				
GENERAL SERVICE COST CENTERS						
1.00						1.00
1.01						1.01
1.02						1.02
1.03						1.03
2.00	156,224					2.00
2.01	0	1,129,750				2.01
4.00	0	0	1,127,010			4.00
5.01	0	0	38,942	283,510		5.01
5.02	17,957	113,874	105,520	0	1,886,410	5.02
6.00	0	0	0	0	0	6.00
7.00	0	30,891	10,358	0	857,254	7.00
7.01	7,096	0	14,867	0	297,348	7.01
8.00	0	1,365	0	0	81,954	8.00
8.01	0	0	0	0	38,245	8.01
9.00	0	4,372	23,331	0	152,126	9.00
9.01	0	0	13,971	0	75,894	9.01
10.00	0	32,950	29,971	0	397,375	10.00
10.01	3,249	0	43,826	0	359,182	10.01
11.00	0	7,595	0	0	113,324	11.00
11.01	0	0	0	0	-60,741	11.01
13.00	15,548	0	31,462	0	196,744	13.00
15.00	1,974	6,016	0	0	210,788	15.00
16.00	406	232	21,726	0	173,161	16.00
19.00	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	11,744	149,228	96,531	26,392	1,513,256	30.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
44.00	1,079	0	12,947	0	108,995	44.00
46.00	11,224	0	237,090	0	1,586,451	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	1,744	206,447	14,405	20,135	822,510	50.00
53.00	0	28,591	0	782	91,711	53.00
54.00	63,543	480,185	57,848	72,086	1,656,150	54.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	2,263	3,703	50,800	59,669	694,847	60.00
60.01	0	0	0	0	0	60.01
64.00	0	0	0	14,101	44,652	64.00
65.00	0	1,038	6,597	7,802	83,616	65.00
66.00	4,444	16,428	100,345	35,201	1,028,432	66.00
67.00	0	0	1,875	2,845	91,275	67.00
68.00	0	0	0	212	12,289	68.00
69.00	0	1,267	1,157	3,493	20,291	69.00
71.00	685	0	14,307	4,336	219,255	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	17,138	214,286	73.00
76.00	0	0	0	0	0	76.00
76.01	0	0	0	0	0	76.01
76.02	0	0	3,105	0	17,457	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	133	20,130	55,443	0	1,459,510	88.00
89.00	0	0	0	0	0	89.00
90.00	31	1,915	6,961	0	173,810	90.00
91.00	3,461	21,900	60,024	19,318	1,735,118	91.00
92.00	0	0	0	0	0	92.00
93.00	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	0	0	0	0	0	109.00
110.00	0	0	0	0	0	110.00
111.00	0	0	0	0	0	111.00
113.00	0	0	0	0	0	113.00
118.00	146,581	1,128,127	1,053,409	283,510	16,352,975	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	194	0	0	23,638	190.00
192.00	0	0	0	0	27,822	192.00
192.01	0	0	0	0	0	192.01
194.00	0	0	0	0	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	ADMITTING	Subtotal	
	NEW MVBLE EQUIP	NEW MVBLE EQUIP NEW HO					
	2.00	2.01	4.00				
194.01 ASSISTED LIVING UNITS	7,542	0	46,616	0	450,126	194.01	
194.02 ADULT DAY CARE	1,714	0	24,846	0	168,936	194.02	
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03	
194.04 IDLE SPACE	0	0	0	0	41,566	194.04	
194.05 COMMUNITY FITNESS CENTER	387	1,429	2,139	0	55,977	194.05	
200.00 Cross Foot Adjustments					0	200.00	
201.00 Negative Cost Centers	0	0	0	0	0	201.00	
202.00 TOTAL (sum lines 118-201)	156,224	1,129,750	1,127,010	283,510	17,121,040	202.00	

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Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	
	5.02	6.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 NEW CAP REL COSTS-2007 MOB						1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	1,886,410					5.02
6.00 MAINTENANCE & REPAIRS	0	0				6.00
7.00 OPERATION OF PLANT	126,051	0	983,305			7.00
7.01 OPERATION OF PLANT-SCC	0	0	0	297,348		7.01
8.00 LAUNDRY & LINEN SERVICE	12,051	0	8,107	0	102,112	8.00
8.01 LAUNDRY & LINEN SERVICE-SCC	0	0	0	938	0	8.01
9.00 HOUSEKEEPING	22,369	0	6,149	0	5,349	9.00
9.01 HOUSEKEEPING-SCC	0	0	0	1,783	0	9.01
10.00 DIETARY	58,430	0	28,718	0	755	10.00
10.01 DIETARY-SCC	0	0	0	6,930	0	10.01
11.00 CAFETERIA	16,663	0	44,295	0	0	11.00
11.01 CAFETERIA-SCC	0	0	0	0	0	11.01
13.00 NURSING ADMINISTRATION	28,929	0	2,915	3,107	0	13.00
15.00 PHARMACY	30,994	0	17,604	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	25,462	0	15,646	0	0	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	222,509	0	203,826	0	27,655	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	0	0	0	8,133	0	44.00
46.00 OTHER LONG TERM CARE	0	0	0	84,610	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	120,942	0	122,614	0	8,700	50.00
53.00 ANESTHESIOLOGY	13,485	0	1,230	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	243,520	0	82,692	0	6,104	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	102,170	0	24,505	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	6,566	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	12,295	0	4,281	0	0	65.00
66.00 PHYSICAL THERAPY	151,221	0	106,035	0	24,987	66.00
67.00 OCCUPATIONAL THERAPY	13,421	0	6,149	0	1,907	67.00
68.00 SPEECH PATHOLOGY	1,807	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	2,984	0	2,687	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	32,239	0	15,532	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	31,509	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	2,567	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	214,606	0	121,589	0	1,595	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	25,557	0	28,331	0	372	90.00
91.00 EMERGENCY	255,126	0	123,502	0	22,511	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,773,473	0	966,407	105,501	99,935	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,476	0	6,764	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	4,091	0	0	0	0	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	66,187	0	0	92,555	0	194.01

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Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	OPERATION OF	LAUNDRY &	
	ADMINISTRATIVE AND GENERAL	REPAIRS	PLANT	PLANT-SCC	LINEN SERVICE	
	5.02	6.00	7.00	7.01	8.00	
194.02 ADULT DAY CARE	24,840	0	0	7,491	0	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 IDLE SPACE	6,112	0	0	91,801	0	194.04
194.05 COMMUNITY FITNESS CENTER	8,231	0	10,134	0	2,177	194.05
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)	1,886,410	0	983,305	297,348	102,112	202.00

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Cost Center Description	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-S-CC	DIETARY	DIETARY-SCC	
	8.01	9.00	9.01	10.00	10.01	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 NEW CAP REL COSTS-2007 MOB						1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 OPERATION OF PLANT-SCC						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
8.01 LAUNDRY & LINEN SERVICE-SCC	39,183					8.01
9.00 HOUSEKEEPING	0	185,993				9.00
9.01 HOUSEKEEPING-SCC	0	0	77,677			9.01
10.00 DIETARY	0	5,993	0	491,271		10.00
10.01 DIETARY-SCC	0	0	2,654	0	368,766	10.01
11.00 CAFETERIA	0	9,244	0	362,407	0	11.00
11.01 CAFETERIA-SCC	0	0	0	0	76,858	11.01
13.00 NURSING ADMINISTRATION	0	608	1,190	0	0	13.00
15.00 PHARMACY	0	3,674	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	3,265	0	0	0	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	42,535	0	128,864	0	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	3,437	0	3,115	0	10,197	44.00
46.00 OTHER LONG TERM CARE	35,746	0	32,403	0	193,776	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	25,587	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	257	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	17,256	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	5,114	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	893	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	8,060	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	466	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	561	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,241	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	25,373	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	5,912	0	0	0	90.00
91.00 EMERGENCY	0	25,773	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	39,183	183,812	39,362	491,271	280,831	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,411	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	0	0	35,446	0	74,920	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	DIETARY	DIETARY-SCC	
		8.01	9.00	9.01	10.00	10.01	
194.02	ADULT DAY CARE	0	0	2,869	0	13,015	194.02
194.03	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	IDLE SPACE	0	0	0	0	0	194.04
194.05	COMMUNITY FITNESS CENTER	0	770	0	0	0	194.05
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)	39,183	185,993	77,677	491,271	368,766	202.00

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Cost Center Description	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	11.01	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 NEW CAP REL COSTS-2007 MOB						1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 OPERATION OF PLANT-SCC						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
8.01 LAUNDRY & LINEN SERVICE-SCC						8.01
9.00 HOUSEKEEPING						9.00
9.01 HOUSEKEEPING-SCC						9.01
10.00 DIETARY						10.00
10.01 DIETARY-SCC						10.01
11.00 CAFETERIA	545,933					11.00
11.01 CAFETERIA-SCC	0	16,117				11.01
13.00 NURSING ADMINISTRATION	14,223	0	247,716			13.00
15.00 PHARMACY	0	0	0	263,060		15.00
16.00 MEDICAL RECORDS & LIBRARY	22,813	0	0	0	240,347	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	88,387	0	247,716	0	215,805	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	0	604	0	0	0	44.00
46.00 OTHER LONG TERM CARE	0	11,453	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	12,746	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	66,221	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	58,648	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	118,743	0	64.00
65.00 RESPIRATORY THERAPY	8,405	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	83,585	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	6,373	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	831	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,701	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	144,317	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	90,235	0	0	0	552	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	16,809	0	0	0	2,371	90.00
91.00 EMERGENCY	53,660	0	0	0	21,619	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	538,637	12,057	247,716	263,060	240,347	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	0	2,900	0	0	0	194.01

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Cost Center Description	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	11.01	13.00	15.00	16.00	
194.02 ADULT DAY CARE	0	1,160	0	0	0	0 194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	0 194.03
194.04 IDLE SPACE	0	0	0	0	0	0 194.04
194.05 COMMUNITY FITNESS CENTER	7,296	0	0	0	0	0 194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	545,933	16,117	247,716	263,060	240,347	202.00

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	NEW CAP REL COSTS-2007 MOB					1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	EMPLOYEE BENEFITS					4.00
5.01	ADMITTING					5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
7.01	OPERATION OF PLANT-SCC					7.01
8.00	LAUNDRY & LINEN SERVICE					8.00
8.01	LAUNDRY & LINEN SERVICE-SCC					8.01
9.00	HOUSEKEEPING					9.00
9.01	HOUSEKEEPING-SCC					9.01
10.00	DIETARY					10.00
10.01	DIETARY-SCC					10.01
11.00	CAFETERIA					11.00
11.01	CAFETERIA-SCC					11.01
13.00	NURSING ADMINISTRATION					13.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
19.00	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	2,690,553	0	2,690,553	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
44.00	SKILLED NURSING FACILITY	0	134,481	0	134,481	44.00
46.00	OTHER LONG TERM CARE	0	1,944,439	0	1,944,439	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	1,113,099	0	1,113,099	50.00
53.00	ANESTHESIOLOGY	0	106,683	0	106,683	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,071,943	0	2,071,943	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	885,284	0	885,284	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	169,961	0	169,961	64.00
65.00	RESPIRATORY THERAPY	0	109,490	0	109,490	65.00
66.00	PHYSICAL THERAPY	0	1,402,320	0	1,402,320	66.00
67.00	OCCUPATIONAL THERAPY	0	119,591	0	119,591	67.00
68.00	SPEECH PATHOLOGY	0	14,096	0	14,096	68.00
69.00	ELECTROCARDIOLOGY	0	27,354	0	27,354	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	285,968	0	285,968	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	390,112	0	390,112	73.00
76.00	SLEEP LAB	0	0	0	0	76.00
76.01	PAIN CLINIC	0	0	0	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0	20,024	0	20,024	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,913,460	0	1,913,460	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	253,162	0	253,162	90.00
91.00	EMERGENCY	0	2,237,309	0	2,237,309	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	15,889,329	0	15,889,329	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	35,289	0	35,289	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	31,913	0	31,913	192.00
192.01	MIDWEST MEDICAL CLINIC	0	0	0	0	192.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141302

Period:
From 10/01/2010
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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
194.00	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	ASSISTED LIVING UNITS	0	722,134	0	722,134	194.01
194.02	ADULT DAY CARE	0	218,311	0	218,311	194.02
194.03	GRANT FUNDED PROGRAMS	0	0	0	0	194.03
194.04	IDLE SPACE	0	139,479	0	139,479	194.04
194.05	COMMUNITY FITNESS CENTER	0	84,585	0	84,585	194.05
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	17,121,040	0	17,121,040	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			NEW 2007 MOB	
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL		
		0	1.00	1.01		1.02
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	NEW CAP REL COSTS-2007 MOB					1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.01	ADMITTING	0	0	0	59,753	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL	0	17,827	34,378	388,279	5.02
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	0	0	278,086	7.00
7.01	OPERATION OF PLANT-SCC	0	4,245	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	0	0	0	28,101	8.00
8.01	LAUNDRY & LINEN SERVICE-SCC	0	425	0	0	8.01
9.00	HOUSEKEEPING	0	0	0	21,312	9.00
9.01	HOUSEKEEPING-SCC	0	807	0	0	9.01
10.00	DIETARY	0	0	0	99,536	10.00
10.01	DIETARY-SCC	0	3,138	0	0	10.01
11.00	CAFETERIA	0	0	0	153,528	11.00
11.01	CAFETERIA-SCC	0	0	0	0	11.01
13.00	NURSING ADMINISTRATION	0	1,407	0	10,104	13.00
15.00	PHARMACY	0	0	0	61,016	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	54,228	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	0	706,465	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
44.00	SKILLED NURSING FACILITY	0	3,683	0	0	44.00
46.00	OTHER LONG TERM CARE	0	38,310	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	424,984	50.00
53.00	ANESTHESIOLOGY	0	0	0	4,262	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	286,611	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	84,934	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	14,840	65.00
66.00	PHYSICAL THERAPY	0	0	0	367,519	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	21,312	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	9,314	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	53,833	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	SLEEP LAB	0	0	0	0	76.00
76.01	PAIN CLINIC	0	0	0	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	421,431	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	0	0	98,195	90.00
91.00	EMERGENCY	0	0	0	428,062	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	69,842	34,378	4,075,705	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	23,444	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			NEW 2007 MOB	
		NEW BLDG & FIXT	NEW ALU BLDG	NEW 2007 HOSPITAL		
		0	1.00	1.01		
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	0	0	73,979	0	0	194.01
194.02 ADULT DAY CARE	0	0	5,987	0	0	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 IDLE SPACE	0	41,566	0	0	0	194.04
194.05 COMMUNITY FITNESS CENTER	0	0	0	35,126	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	111,408	114,344	4,134,275	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2010
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Cost Center Description	CAPITAL RELATED COSTS		Subtotal 2A	EMPLOYEE BENEFITS 4.00	ADMITTING 5.01	
	NEW MVBLE EQUIP 2.00	NEW MVBLE EQUIP NEW HO 2.01				
	GENERAL SERVICE COST CENTERS					
1.00						1.00
1.01						1.01
1.02						1.02
1.03						1.03
2.00						2.00
2.01						2.01
4.00	0	0	0	0		4.00
5.01	0	0	59,753	0	59,753	5.01
5.02	17,957	113,874	572,315	0	0	5.02
6.00	0	0	0	0	0	6.00
7.00	0	30,891	308,977	0	0	7.00
7.01	7,096	0	11,341	0	0	7.01
8.00	0	1,365	29,466	0	0	8.00
8.01	0	0	425	0	0	8.01
9.00	0	4,372	25,684	0	0	9.00
9.01	0	0	807	0	0	9.01
10.00	0	32,950	132,486	0	0	10.00
10.01	3,249	0	6,387	0	0	10.01
11.00	0	7,595	161,123	0	0	11.00
11.01	0	0	0	0	0	11.01
13.00	15,548	0	27,059	0	0	13.00
15.00	1,974	6,016	69,006	0	0	15.00
16.00	406	232	54,866	0	0	16.00
19.00	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	11,744	149,228	867,437	0	5,563	30.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
44.00	1,079	0	4,762	0	0	44.00
46.00	11,224	0	49,534	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	1,744	206,447	633,175	0	4,244	50.00
53.00	0	28,591	32,853	0	165	53.00
54.00	63,543	480,185	830,339	0	15,191	54.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	2,263	3,703	90,900	0	12,576	60.00
60.01	0	0	0	0	0	60.01
64.00	0	0	0	0	2,972	64.00
65.00	0	1,038	15,878	0	1,644	65.00
66.00	4,444	16,428	388,391	0	7,419	66.00
67.00	0	0	21,312	0	600	67.00
68.00	0	0	0	0	45	68.00
69.00	0	1,267	10,581	0	736	69.00
71.00	685	0	54,518	0	914	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	0	3,612	73.00
76.00	0	0	0	0	0	76.00
76.01	0	0	0	0	0	76.01
76.02	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	133	20,130	441,694	0	0	88.00
89.00	0	0	0	0	0	89.00
90.00	31	1,915	100,141	0	0	90.00
91.00	3,461	21,900	453,423	0	4,072	91.00
92.00	0	0	0	0	0	92.00
93.00	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	0	0	0	0	0	109.00
110.00	0	0	0	0	0	110.00
111.00	0	0	0	0	0	111.00
113.00	0	0	0	0	0	113.00
118.00	146,581	1,128,127	5,454,633	0	59,753	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	194	23,638	0	0	190.00
192.00	0	0	0	0	0	192.00
192.01	0	0	0	0	0	192.01
194.00	0	0	0	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

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Cost Center Description	CAPITAL RELATED COSTS			Subtotal 2A	EMPLOYEE BENEFITS 4.00	ADMITTING 5.01	
	NEW MVBLE EQUIP 2.00	NEW MVBLE EQUIP NEW HO 2.01					
	194.01 ASSISTED LIVING UNITS	7,542	0				
194.02 ADULT DAY CARE	1,714	0	7,701	0	0	0	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	0	194.03
194.04 IDLE SPACE	0	0	41,566	0	0	0	194.04
194.05 COMMUNITY FITNESS CENTER	387	1,429	36,942	0	0	0	194.05
200.00 Cross Foot Adjustments			0				200.00
201.00 Negative Cost Centers	0	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	156,224	1,129,750	5,646,001	0	0	59,753	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

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Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-SCC	LAUNDRY & LINEN SERVICE	
	5.02	6.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 NEW CAP REL COSTS-2007 MOB						1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	572,315					5.02
6.00 MAINTENANCE & REPAIRS	0	0				6.00
7.00 OPERATION OF PLANT	38,242	0	347,219			7.00
7.01 OPERATION OF PLANT-SCC	0	0	0	11,341		7.01
8.00 LAUNDRY & LINEN SERVICE	3,656	0	2,863	0	35,985	8.00
8.01 LAUNDRY & LINEN SERVICE-SCC	0	0	0	36	0	8.01
9.00 HOUSEKEEPING	6,786	0	2,171	0	1,885	9.00
9.01 HOUSEKEEPING-SCC	0	0	0	68	0	9.01
10.00 DIETARY	17,727	0	10,141	0	266	10.00
10.01 DIETARY-SCC	0	0	0	264	0	10.01
11.00 CAFETERIA	5,055	0	15,641	0	0	11.00
11.01 CAFETERIA-SCC	0	0	0	0	0	11.01
13.00 NURSING ADMINISTRATION	8,777	0	1,029	119	0	13.00
15.00 PHARMACY	9,403	0	6,216	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	7,725	0	5,525	0	0	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	67,506	0	71,975	0	9,747	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	0	0	0	310	0	44.00
46.00 OTHER LONG TERM CARE	0	0	0	3,227	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	36,692	0	43,297	0	3,066	50.00
53.00 ANESTHESIOLOGY	4,091	0	434	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	73,881	0	29,200	0	2,151	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	30,997	0	8,653	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	1,992	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	3,730	0	1,512	0	0	65.00
66.00 PHYSICAL THERAPY	45,878	0	37,442	0	8,805	66.00
67.00 OCCUPATIONAL THERAPY	4,072	0	2,171	0	672	67.00
68.00 SPEECH PATHOLOGY	548	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	905	0	949	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,781	0	5,484	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	9,559	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	779	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	65,109	0	42,935	0	562	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	7,754	0	10,004	0	131	90.00
91.00 EMERGENCY	77,408	0	43,610	0	7,933	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	538,053	0	341,252	4,024	35,218	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	0	2,388	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	1,241	0	0	0	0	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	20,080	0	0	3,530	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141302

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Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	OPERATION OF	LAUNDRY &	
	ADMINISTRATIVE AND GENERAL	REPAIRS	PLANT	PLANT-SCC	LINEN SERVICE	
	5.02	6.00	7.00	7.01	8.00	
194.02 ADULT DAY CARE	7,536	0	0	286	0	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 IDLE SPACE	1,854	0	0	3,501	0	194.04
194.05 COMMUNITY FITNESS CENTER	2,497	0	3,579	0	767	194.05
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)	572,315	0	347,219	11,341	35,985	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	DIETARY	DIETARY-SCC	
	8.01	9.00	9.01	10.00	10.01	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 NEW CAP REL COSTS-2007 MOB						1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 OPERATION OF PLANT-SCC						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
8.01 LAUNDRY & LINEN SERVICE-SCC	461					8.01
9.00 HOUSEKEEPING	0	36,526				9.00
9.01 HOUSEKEEPING-SCC	0	0	875			9.01
10.00 DIETARY	0	1,177	0	161,797		10.00
10.01 DIETARY-SCC	0	0	30		6,681	10.01
11.00 CAFETERIA	0	1,815	0	119,356	0	11.00
11.01 CAFETERIA-SCC	0	0	0	0	1,392	11.01
13.00 NURSING ADMINISTRATION	0	119	13	0	0	13.00
15.00 PHARMACY	0	721	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	641	0	0	0	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	8,356	0	42,441	0	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	40	0	35	0	185	44.00
46.00 OTHER LONG TERM CARE	421	0	365	0	3,511	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	5,025	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	50	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	3,389	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	1,004	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	175	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	1,583	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	91	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	110	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	637	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	4,983	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	1,161	0	0	0	90.00
91.00 EMERGENCY	0	5,061	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	461	36,098	443	161,797	5,088	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	277	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	0	0	400	0	1,357	194.01

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		LAUNDRY & LINEN SERVICE-SCC	HOUSEKEEPING	HOUSEKEEPING-SCC	DIETARY	DIETARY-SCC	
		8.01	9.00	9.01	10.00	10.01	
194.02	ADULT DAY CARE	0	0	32	0	236	194.02
194.03	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	IDLE SPACE	0	0	0	0	0	194.04
194.05	COMMUNITY FITNESS CENTER	0	151	0	0	0	194.05
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)	461	36,526	875	161,797	6,681	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	11.01	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 NEW CAP REL COSTS-2007 MOB						1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 OPERATION OF PLANT-SCC						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
8.01 LAUNDRY & LINEN SERVICE-SCC						8.01
9.00 HOUSEKEEPING						9.00
9.01 HOUSEKEEPING-SCC						9.01
10.00 DIETARY						10.00
10.01 DIETARY-SCC						10.01
11.00 CAFETERIA	278,597					11.00
11.01 CAFETERIA-SCC	0	292				11.01
13.00 NURSING ADMINISTRATION	7,258	0	44,374			13.00
15.00 PHARMACY	0	0	0	85,346		15.00
16.00 MEDICAL RECORDS & LIBRARY	11,642	0	0	0	80,399	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	45,105	0	44,374	0	72,190	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	0	11	0	0	0	44.00
46.00 OTHER LONG TERM CARE	0	207	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	6,504	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	33,794	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	29,929	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	38,525	0	64.00
65.00 RESPIRATORY THERAPY	4,289	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	42,654	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	3,252	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	424	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,012	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	46,821	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	46,049	0	0	0	184	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	8,578	0	0	0	793	90.00
91.00 EMERGENCY	27,384	0	0	0	7,232	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	274,874	218	44,374	85,346	80,399	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	0	53	0	0	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	CAFETERIA	CAFETERIA-SCC	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	11.01	13.00	15.00	16.00	
194.02 ADULT DAY CARE	0	21	0	0	0	0 194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	0 194.03
194.04 IDLE SPACE	0	0	0	0	0	0 194.04
194.05 COMMUNITY FITNESS CENTER	3,723	0	0	0	0	0 194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	24,393	1,100	0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	302,990	1,392	44,374	85,346	80,399	202.00

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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	NEW CAP REL COSTS-ALU BLDG					1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL					1.02
1.03	NEW CAP REL COSTS-2007 MOB					1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO					2.01
4.00	EMPLOYEE BENEFITS					4.00
5.01	ADMITTING					5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL					5.02
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
7.01	OPERATION OF PLANT-SCC					7.01
8.00	LAUNDRY & LINEN SERVICE					8.00
8.01	LAUNDRY & LINEN SERVICE-SCC					8.01
9.00	HOUSEKEEPING					9.00
9.01	HOUSEKEEPING-SCC					9.01
10.00	DIETARY					10.00
10.01	DIETARY-SCC					10.01
11.00	CAFETERIA					11.00
11.01	CAFETERIA-SCC					11.01
13.00	NURSING ADMINISTRATION					13.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
19.00	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		1,234,694	0	1,234,694	30.00
41.00	SUBPROVIDER - IRF		0	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
44.00	SKILLED NURSING FACILITY		5,343	0	5,343	44.00
46.00	OTHER LONG TERM CARE		57,265	0	57,265	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		732,003	0	732,003	50.00
53.00	ANESTHESIOLOGY		37,593	0	37,593	53.00
54.00	RADIOLOGY-DIAGNOSTIC		987,945	0	987,945	54.00
57.00	CT SCAN		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		174,059	0	174,059	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
64.00	INTRAVENOUS THERAPY		43,489	0	43,489	64.00
65.00	RESPIRATORY THERAPY		27,228	0	27,228	65.00
66.00	PHYSICAL THERAPY		532,172	0	532,172	66.00
67.00	OCCUPATIONAL THERAPY		32,170	0	32,170	67.00
68.00	SPEECH PATHOLOGY		593	0	593	68.00
69.00	ELECTROCARDIOLOGY		13,705	0	13,705	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		79,346	0	79,346	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		59,992	0	59,992	73.00
76.00	SLEEP LAB		0	0	0	76.00
76.01	PAIN CLINIC		0	0	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY		779	0	779	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		601,516	0	601,516	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	CLINIC		128,562	0	128,562	90.00
91.00	EMERGENCY		626,123	0	626,123	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
93.00	FAMILY PRACTICE		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION		0	0	0	109.00
110.00	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	ISLET ACQUISITION		0	0	0	111.00
113.00	INTEREST EXPENSE		0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	5,374,577	0	5,374,577	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN		27,357	0	27,357	190.00
192.00	PHYSICIANS' PRIVATE OFFICES		1,241	0	1,241	192.00
192.01	MIDWEST MEDICAL CLINIC		0	0	0	192.01

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
194.00	OTHER NONREIMBURSABLE		0	0	0	194.00
194.01	ASSISTED LIVING UNITS		106,941	0	106,941	194.01
194.02	ADULT DAY CARE		15,812	0	15,812	194.02
194.03	GRANT FUNDED PROGRAMS		0	0	0	194.03
194.04	IDLE SPACE		46,921	0	46,921	194.04
194.05	COMMUNITY FITNESS CENTER		47,659	0	47,659	194.05
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	25,493	0	25,493	201.00
202.00	TOTAL (sum lines 118-201)	0	5,646,001	0	5,646,001	202.00

Cost Center Description	CAPITAL RELATED COSTS				NEW MVBLE EQUIP (DOLLAR VALUE)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)		
	1.00	1.01	1.02	1.03		
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	50,914					1.00
1.01 NEW CAP REL COSTS-ALU BLDG	0	29,602				1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL	0	0	52,376			1.02
1.03 NEW CAP REL COSTS-2007 MOB	0	0	0	0		1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP					153,149	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO					0	2.01
4.00 EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.01 ADMITTING	0	0	757	0	0	5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	8,147	8,900	4,919	0	17,604	5.02
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	0	0	3,523	0	0	7.00
7.01 OPERATION OF PLANT-SCC	1,940	0	0	0	6,956	7.01
8.00 LAUNDRY & LINEN SERVICE	0	0	356	0	0	8.00
8.01 LAUNDRY & LINEN SERVICE-SCC	194	0	0	0	0	8.01
9.00 HOUSEKEEPING	0	0	270	0	0	9.00
9.01 HOUSEKEEPING-SCC	369	0	0	0	0	9.01
10.00 DIETARY	0	0	1,261	0	0	10.00
10.01 DIETARY-SCC	1,434	0	0	0	3,185	10.01
11.00 CAFETERIA	0	0	1,945	0	0	11.00
11.01 CAFETERIA-SCC	0	0	0	0	0	11.01
13.00 NURSING ADMINISTRATION	643	0	128	0	15,242	13.00
15.00 PHARMACY	0	0	773	0	1,935	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	687	0	398	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	0	8,950	0	11,513	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	1,683	0	0	0	1,058	44.00
46.00 OTHER LONG TERM CARE	17,508	0	0	0	11,003	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	5,384	0	1,710	50.00
53.00 ANESTHESIOLOGY	0	0	54	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	3,631	0	62,292	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	1,076	0	2,218	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	188	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	4,656	0	4,357	66.00
67.00 OCCUPATIONAL THERAPY	0	0	270	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	118	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	682	0	672	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	5,339	0	130	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	1,244	0	30	90.00
91.00 EMERGENCY	0	0	5,423	0	3,393	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	31,918	8,900	51,634	0	143,696	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	297	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	CAPITAL RELATED COSTS				NEW MVBLE EQUIP (DOLLAR VALUE)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW ALU BLDG (SQUARE FEET)	NEW 2007 HOSPITAL (SQUARE FEET)	NEW 2007 MOB (SQUARE FEET)		
	1.00	1.01	1.02	1.03		
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	0	19,152	0	0	7,394	194.01
194.02 ADULT DAY CARE	0	1,550	0	0	1,680	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 IDLE SPACE	18,996	0	0	0	0	194.04
194.05 COMMUNITY FITNESS CENTER	0	0	445	0	379	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per wkst. B, Part I)	111,408	114,344	4,134,275	0	156,224	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	2.188160	3.862712	78.934531	0.000000	1.020078	203.00
204.00 Cost to be allocated (per wkst. B, Part II)						204.00
205.00 Unit cost multiplier (wkst. B, Part II)						205.00

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)					
	2.01	4.00	5.01	5A.02	5.02	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 NEW CAP REL COSTS-2007 MOB						1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO	744,645					2.01
4.00 EMPLOYEE BENEFITS	0	4,930,113				4.00
5.01 ADMITTING	0	170,353	11,879,506			5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	75,057	461,597	0	-1,886,410	12,829,256	5.02
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	20,361	45,309	0	0	857,254	7.00
7.01 OPERATION OF PLANT-SCC	0	65,038	0	-297,348	0	7.01
8.00 LAUNDRY & LINEN SERVICE	900	0	0	0	81,954	8.00
8.01 LAUNDRY & LINEN SERVICE-SCC	0	0	0	-38,245	0	8.01
9.00 HOUSEKEEPING	2,882	102,061	0	0	152,126	9.00
9.01 HOUSEKEEPING-SCC	0	61,116	0	-75,894	0	9.01
10.00 DIETARY	21,718	131,109	0	0	397,375	10.00
10.01 DIETARY-SCC	0	191,719	0	-359,182	0	10.01
11.00 CAFETERIA	5,006	0	0	0	113,324	11.00
11.01 CAFETERIA-SCC	0	0	0	60,741	0	11.01
13.00 NURSING ADMINISTRATION	0	137,632	0	0	196,744	13.00
15.00 PHARMACY	3,965	0	0	0	210,788	15.00
16.00 MEDICAL RECORDS & LIBRARY	153	95,039	0	0	173,161	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	98,360	422,275	1,105,881	0	1,513,256	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	0	56,636	0	-108,995	0	44.00
46.00 OTHER LONG TERM CARE	0	1,037,151	0	-1,586,451	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	136,074	63,015	843,710	0	822,510	50.00
53.00 ANESTHESIOLOGY	18,845	0	32,768	0	91,711	53.00
54.00 RADIOLOGY-DIAGNOSTIC	316,501	253,056	3,020,326	0	1,656,150	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	2,441	222,226	2,500,290	0	694,847	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	590,877	0	44,652	64.00
65.00 RESPIRATORY THERAPY	684	28,860	326,912	0	83,616	65.00
66.00 PHYSICAL THERAPY	10,828	438,962	1,474,989	0	1,028,432	66.00
67.00 OCCUPATIONAL THERAPY	0	8,202	119,193	0	91,275	67.00
68.00 SPEECH PATHOLOGY	0	0	8,898	0	12,289	68.00
69.00 ELECTROCARDIOLOGY	835	5,060	146,373	0	20,291	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,584	181,696	0	219,255	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	718,130	0	214,286	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	13,582	0	0	17,457	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	13,268	242,536	0	0	1,459,510	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	1,262	30,453	0	0	173,810	90.00
91.00 EMERGENCY	14,435	262,575	809,463	0	1,735,118	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	743,575	4,608,146	11,879,506	-4,291,784	12,061,191	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	0	0	0	23,638	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	NEW MVBLE EQUIP NEW HO (DOLLAR VALUE)						
	2.01		4.00	5.01	5A.02	5.02	
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	27,822	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	0	0	203,923	0	0	450,126	194.01
194.02 ADULT DAY CARE	0	0	108,688	0	0	168,936	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	0	194.03
194.04 IDLE SPACE	0	0	0	0	0	41,566	194.04
194.05 COMMUNITY FITNESS CENTER	942	0	9,356	0	0	55,977	194.05
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)	1,129,750		1,127,010	283,510		1,886,410	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1.517166		0.228597	0.023865		0.147040	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0	59,753		572,315	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000	0.005030		0.044610	205.00

Cost Center Description		MAINTENANCE & REPAIRS (SQARE FEET)	OPERATION OF PLANT (SQARE FT)	OPERATION OF PLANT-SCC (SQARE FT SCC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	LAUNDRY & LINEN SERVICE-SCC (POUNDS OF LAUNDRY)	
		6.00	7.00	7.01	8.00	8.01	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	NEW CAP REL COSTS-2007 MOB						1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	MAINTENANCE & REPAIRS	0					6.00
7.00	OPERATION OF PLANT	0	43,177				7.00
7.01	OPERATION OF PLANT-SCC	0	0	61,529			7.01
8.00	LAUNDRY & LINEN SERVICE	0	356	0	118,137		8.00
8.01	LAUNDRY & LINEN SERVICE-SCC	0	0	194	0	118,796	8.01
9.00	HOUSEKEEPING	0	270	0	6,188	0	9.00
9.01	HOUSEKEEPING-SCC	0	0	369	0	0	9.01
10.00	DIETARY	0	1,261	0	874	0	10.00
10.01	DIETARY-SCC	0	0	1,434	0	0	10.01
11.00	CAFETERIA	0	1,945	0	0	0	11.00
11.01	CAFETERIA-SCC	0	0	0	0	0	11.01
13.00	NURSING ADMINISTRATION	0	128	643	0	0	13.00
15.00	PHARMACY	0	773	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	687	0	0	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	8,950	0	31,996	0	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
44.00	SKILLED NURSING FACILITY	0	0	1,683	0	10,421	44.00
46.00	OTHER LONG TERM CARE	0	0	17,508	0	108,375	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	5,384	0	10,065	0	50.00
53.00	ANESTHESIOLOGY	0	54	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,631	0	7,062	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	1,076	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	188	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	4,656	0	28,908	0	66.00
67.00	OCCUPATIONAL THERAPY	0	270	0	2,206	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	118	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	682	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	SLEEP LAB	0	0	0	0	0	76.00
76.01	PAIN CLINIC	0	0	0	0	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	5,339	0	1,845	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	1,244	0	430	0	90.00
91.00	EMERGENCY	0	5,423	0	26,044	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	42,435	21,831	115,618	118,796	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	297	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FT)	OPERATION OF PLANT-SCC (SQUARE FT SCC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	LAUNDRY & LINEN SERVICE-SCC (POUNDS OF LAUNDRY)	
	6.00	7.00	7.01	8.00	8.01	
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	0	0	19,152	0	0	194.01
194.02 ADULT DAY CARE	0	0	1,550	0	0	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 IDLE SPACE	0	0	18,996	0	0	194.04
194.05 COMMUNITY FITNESS CENTER	0	445	0	2,519	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per wkst. B, Part I)	0	983,305	297,348	102,112	39,183	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	0.000000	22.773815	4.832648	0.864352	0.329834	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	0	347,219	11,341	35,985	461	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.000000	8.041758	0.184320	0.304604	0.003881	205.00

Cost Center Description	HOUSEKEEPING (SQARE FT)	HOUSEKEEPING-S CC (SQARE FT SCC)	DIETARY (MEALS SERVED)	DIETARY-SCC (MEALS SERVEDSCC)	CAFETERIA (FTE)	
	9.00	9.01	10.00	10.01	11.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-ALU BLDG						1.01
1.02 NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03 NEW CAP REL COSTS-2007 MOB						1.03
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 OPERATION OF PLANT-SCC						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
8.01 LAUNDRY & LINEN SERVICE-SCC						8.01
9.00 HOUSEKEEPING	39,136					9.00
9.01 HOUSEKEEPING-SCC	0	41,970				9.01
10.00 DIETARY	1,261	0	21,532			10.00
10.01 DIETARY-SCC	0	1,434	0	96,848		10.01
11.00 CAFETERIA	1,945	0	15,884	0	5,911	11.00
11.01 CAFETERIA-SCC	0	0	0	20,185	0	11.01
13.00 NURSING ADMINISTRATION	128	643	0	0	154	13.00
15.00 PHARMACY	773	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	687	0	0	0	247	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,950	0	5,648	0	957	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
44.00 SKILLED NURSING FACILITY	0	1,683	0	2,678	0	44.00
46.00 OTHER LONG TERM CARE	0	17,508	0	50,891	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	5,384	0	0	0	138	50.00
53.00 ANESTHESIOLOGY	54	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,631	0	0	0	717	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,076	0	0	0	635	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	188	0	0	0	91	65.00
66.00 PHYSICAL THERAPY	1,696	0	0	0	905	66.00
67.00 OCCUPATIONAL THERAPY	98	0	0	0	69	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	118	0	0	0	9	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	682	0	0	0	170	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	5,339	0	0	0	977	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	1,244	0	0	0	182	90.00
91.00 EMERGENCY	5,423	0	0	0	581	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	38,677	21,268	21,532	73,754	5,832	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	297	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

worksheet B-1

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		HOUSEKEEPING (SQUARE FT)	HOUSEKEEPING-S CC (SQUARE FT SCC)	DIETARY (MEALS SERVED)	DIETARY-SCC (MEALS SERVEDSCC)	CAFETERIA (FTE)	
		9.00	9.01	10.00	10.01	11.00	
194.01	ASSISTED LIVING UNITS	0	19,152	0	19,676	0	194.01
194.02	ADULT DAY CARE	0	1,550	0	3,418	0	194.02
194.03	GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04	IDLE SPACE	0	0	0	0	0	194.04
194.05	COMMUNITY FITNESS CENTER	162	0	0	0	79	194.05
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)	185,993	77,677	491,271	368,766	545,933	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	4.752479	1.850774	22.815855	3.807678	92.358823	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	36,526	875	161,797	6,681	302,990	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.933309	0.020848	7.514258	0.068984	47.131957	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		CAFETERIA-SCC (FTE's -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
		11.01	13.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-ALU BLDG						1.01
1.02	NEW CAP REL COSTS-2007 HOSPITAL						1.02
1.03	NEW CAP REL COSTS-2007 MOB						1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP NEW HO						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMITTING						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT-SCC						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
8.01	LAUNDRY & LINEN SERVICE-SCC						8.01
9.00	HOUSEKEEPING						9.00
9.01	HOUSEKEEPING-SCC						9.01
10.00	DIETARY						10.00
10.01	DIETARY-SCC						10.01
11.00	CAFETERIA						11.00
11.01	CAFETERIA-SCC	4,751					11.01
13.00	NURSING ADMINISTRATION	0	2,919				13.00
15.00	PHARMACY	0	0	1,309,007			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	4,358		16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	2,919	0	3,913		30.00
41.00	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0	0		42.00
44.00	SKILLED NURSING FACILITY	178	0	0	0		44.00
46.00	OTHER LONG TERM CARE	3,376	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	100	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	590,877	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	718,130	0	0	73.00
76.00	SLEEP LAB	0	0	0	0	0	76.00
76.01	PAIN CLINIC	0	0	0	0	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	10	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	43	0	90.00
91.00	EMERGENCY	0	0	0	392	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,554	2,919	1,309,007	4,358	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	MIDWEST MEDICAL CLINIC	0	0	0	0	0	192.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	CAFETERIA-SCC (FTE'S -SCC)	NURSING ADMINISTRATION (HOURS OF SERVICE)	PHARMACY (GROSS CHARGES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
	11.01	13.00	15.00	16.00	19.00	
194.00 OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01 ASSISTED LIVING UNITS	855	0	0	0	0	194.01
194.02 ADULT DAY CARE	342	0	0	0	0	194.02
194.03 GRANT FUNDED PROGRAMS	0	0	0	0	0	194.03
194.04 IDLE SPACE	0	0	0	0	0	194.04
194.05 COMMUNITY FITNESS CENTER	0	0	0	0	0	194.05
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)	16,117	247,716	263,060	240,347		202.00
203.00 Unit cost multiplier (wkst. B, Part I)	3.392338	84.863309	0.200961	55.150757	0.000000	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	1,392	44,374	85,346	80,399		204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.061461	15.201781	0.065199	18.448600	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Cost
			Total Costs	RCE Disallowance	Total Costs		
							3.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	2,690,553		2,690,553	0	2,690,553	30.00	
41.00 SUBPROVIDER - IRF	0		0	0	0	41.00	
42.00 SUBPROVIDER	0		0	0	0	42.00	
44.00 SKILLED NURSING FACILITY	134,481		134,481	0	134,481	44.00	
46.00 OTHER LONG TERM CARE	1,944,439		1,944,439	0	1,944,439	46.00	
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	1,113,099		1,113,099	0	1,113,099	50.00	
53.00 ANESTHESIOLOGY	106,683		106,683	0	106,683	53.00	
54.00 RADIOLOGY-DIAGNOSTIC	2,071,943		2,071,943	0	2,071,943	54.00	
57.00 CT SCAN	0		0	0	0	57.00	
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00	
59.00 CARDIAC CATHETERIZATION	0		0	0	0	59.00	
60.00 LABORATORY	885,284		885,284	0	885,284	60.00	
60.01 BLOOD LABORATORY	0		0	0	0	60.01	
64.00 INTRAVENOUS THERAPY	169,961		169,961	0	169,961	64.00	
65.00 RESPIRATORY THERAPY	109,490	0	109,490	0	109,490	65.00	
66.00 PHYSICAL THERAPY	1,402,320	0	1,402,320	0	1,402,320	66.00	
67.00 OCCUPATIONAL THERAPY	119,591	0	119,591	0	119,591	67.00	
68.00 SPEECH PATHOLOGY	14,096	0	14,096	0	14,096	68.00	
69.00 ELECTROCARDIOLOGY	27,354		27,354	0	27,354	69.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	285,968		285,968	0	285,968	71.00	
72.00 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00	
73.00 DRUGS CHARGED TO PATIENTS	390,112		390,112	0	390,112	73.00	
76.00 SLEEP LAB	0		0	0	0	76.00	
76.01 PAIN CLINIC	0		0	0	0	76.01	
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	20,024		20,024	0	20,024	76.02	
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	1,913,460		1,913,460	0	1,913,460	88.00	
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00	
90.00 CLINIC	253,162		253,162	0	253,162	90.00	
91.00 EMERGENCY	2,237,309		2,237,309	0	2,237,309	91.00	
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	135,823		135,823	0	135,823	92.00	
93.00 FAMILY PRACTICE	0		0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
99.10 CORF	0		0		0	99.10	
SPECIAL PURPOSE COST CENTERS							
109.00 PANCREAS ACQUISITION	0		0		0	109.00	
110.00 INTESTINAL ACQUISITION	0		0		0	110.00	
111.00 ISLET ACQUISITION	0		0		0	111.00	
113.00 INTEREST EXPENSE						113.00	
200.00 Subtotal (see instructions)	16,025,152	0	16,025,152	0	16,025,152	200.00	
201.00 Less Observation Beds	135,823		135,823		135,823	201.00	
202.00 Total (see instructions)	15,889,329	0	15,889,329	0	15,889,329	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Title XVIII			Hospital	Cost		
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	981,788		981,788			30.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
44.00	SKILLED NURSING FACILITY	302,526		302,526			44.00
46.00	OTHER LONG TERM CARE	3,182,948		3,182,948			46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	20,564	823,146	843,710	1.319291	0.000000	50.00
53.00	ANESTHESIOLOGY	1,827	30,941	32,768	3.255707	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	118,269	2,902,057	3,020,326	0.686000	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	326,713	2,173,577	2,500,290	0.354073	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	INTRAVENOUS THERAPY	128,015	462,862	590,877	0.287642	0.000000	64.00
65.00	RESPIRATORY THERAPY	181,604	145,308	326,912	0.334922	0.000000	65.00
66.00	PHYSICAL THERAPY	201,721	1,273,268	1,474,989	0.950733	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	100,503	18,690	119,193	1.003339	0.000000	67.00
68.00	SPEECH PATHOLOGY	2,973	5,925	8,898	1.584176	0.000000	68.00
69.00	ELECTROCARDIOLOGY	12,683	133,690	146,373	0.186879	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,798	114,898	181,696	1.573882	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	428,667	289,463	718,130	0.543233	0.000000	73.00
76.00	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
76.01	PAIN CLINIC	0	0	0	0.000000	0.000000	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	85,856	0	85,856	0.233228	0.000000	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	1,174,577	1,174,577			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	7,568	102,238	109,806	2.305539	0.000000	90.00
91.00	EMERGENCY	55,355	754,108	809,463	2.763942	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2,000	122,093	124,093	1.094526	0.000000	92.00
93.00	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	6,208,378	10,526,841	16,735,219			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	6,208,378	10,526,841	16,735,219			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
44.00	SKILLED NURSING FACILITY				44.00
46.00	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	SLEEP LAB	0.000000			76.00
76.01	PAIN CLINIC	0.000000			76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0.000000			76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	FAMILY PRACTICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION				109.00
110.00	INTESTINAL ACQUISITION				110.00
111.00	ISLET ACQUISITION				111.00
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part II
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	732,003	843,710	0.867600	578	501	50.00
53.00 ANESTHESIOLOGY	37,593	32,768	1.147247	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	987,945	3,020,326	0.327099	72,461	23,702	54.00
57.00 CT SCAN	0	0	0.000000	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 LABORATORY	174,059	2,500,290	0.069616	185,968	12,946	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00 INTRAVENOUS THERAPY	43,489	590,877	0.073601	23,225	1,709	64.00
65.00 RESPIRATORY THERAPY	27,228	326,912	0.083288	107,540	8,957	65.00
66.00 PHYSICAL THERAPY	532,172	1,474,989	0.360797	17,905	6,460	66.00
67.00 OCCUPATIONAL THERAPY	32,170	119,193	0.269898	4,073	1,099	67.00
68.00 SPEECH PATHOLOGY	593	8,898	0.066644	528	35	68.00
69.00 ELECTROCARDIOLOGY	13,705	146,373	0.093631	10,146	950	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	79,346	181,696	0.436696	37,764	16,491	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	59,992	718,130	0.083539	156,467	13,071	73.00
76.00 SLEEP LAB	0	0	0.000000	0	0	76.00
76.01 PAIN CLINIC	0	0	0.000000	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	779	85,856	0.009073	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	601,516	1,174,577	0.512113	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00 CLINIC	128,562	109,806	1.170810	10	12	90.00
91.00 EMERGENCY	626,123	809,463	0.773504	33,219	25,695	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	124,093	0.000000	1,009	0	92.00
93.00 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00 Total (lines 50-199)	4,077,275	12,267,957		650,893	111,628	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
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: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Title XVIII					Hospital	
	Total	Total Charges	Ratio of Cost	Outpatient	Cost		
	Outpatient Cost (sum of col. 2, 3 and 4)	(from wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	843,710	0.000000	0.000000	578	50.00	
53.00 ANESTHESIOLOGY	0	32,768	0.000000	0.000000	0	53.00	
54.00 RADIOLOGY-DIAGNOSTIC	0	3,020,326	0.000000	0.000000	72,461	54.00	
57.00 CT SCAN	0	0	0.000000	0.000000	0	57.00	
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00	
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00	
60.00 LABORATORY	0	2,500,290	0.000000	0.000000	185,968	60.00	
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01	
64.00 INTRAVENOUS THERAPY	0	590,877	0.000000	0.000000	23,225	64.00	
65.00 RESPIRATORY THERAPY	0	326,912	0.000000	0.000000	107,540	65.00	
66.00 PHYSICAL THERAPY	0	1,474,989	0.000000	0.000000	17,905	66.00	
67.00 OCCUPATIONAL THERAPY	0	119,193	0.000000	0.000000	4,073	67.00	
68.00 SPEECH PATHOLOGY	0	8,898	0.000000	0.000000	528	68.00	
69.00 ELECTROCARDIOLOGY	0	146,373	0.000000	0.000000	10,146	69.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	181,696	0.000000	0.000000	37,764	71.00	
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00	
73.00 DRUGS CHARGED TO PATIENTS	0	718,130	0.000000	0.000000	156,467	73.00	
76.00 SLEEP LAB	0	0	0.000000	0.000000	0	76.00	
76.01 PAIN CLINIC	0	0	0.000000	0.000000	0	76.01	
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	85,856	0.000000	0.000000	0	76.02	
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	1,174,577	0.000000	0.000000	0	88.00	
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00	
90.00 CLINIC	0	109,806	0.000000	0.000000	10	90.00	
91.00 EMERGENCY	0	809,463	0.000000	0.000000	33,219	91.00	
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	124,093	0.000000	0.000000	1,009	92.00	
93.00 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00	
200.00 Total (lines 50-199)	0	12,267,957			650,893	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Title XVIII			Hospital	Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School
	11.00	12.00	13.00	21.00	22.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0	0	0
53.00 ANESTHESIOLOGY	0	0	0	0	0
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
57.00 CT SCAN	0	0	0	0	0
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 LABORATORY	0	0	0	0	0
60.01 BLOOD LABORATORY	0	0	0	0	0
64.00 INTRAVENOUS THERAPY	0	0	0	0	0
65.00 RESPIRATORY THERAPY	0	0	0	0	0
66.00 PHYSICAL THERAPY	0	0	0	0	0
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 SPEECH PATHOLOGY	0	0	0	0	0
69.00 ELECTROCARDIOLOGY	0	0	0	0	0
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 SLEEP LAB	0	0	0	0	0
76.01 PAIN CLINIC	0	0	0	0	0
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0	0	0
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 CLINIC	0	0	0	0	0
91.00 EMERGENCY	0	0	0	0	0
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00 FAMILY PRACTICE	0	0	0	0	0
200.00 Total (Lines 50-199)	0	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
57.00	CT SCAN	0	0			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	CARDIAC CATHETERIZATION	0	0			59.00
60.00	LABORATORY	0	0			60.00
60.01	BLOOD LABORATORY	0	0			60.01
64.00	INTRAVENOUS THERAPY	0	0			64.00
65.00	RESPIRATORY THERAPY	0	0			65.00
66.00	PHYSICAL THERAPY	0	0			66.00
67.00	OCCUPATIONAL THERAPY	0	0			67.00
68.00	SPEECH PATHOLOGY	0	0			68.00
69.00	ELECTROCARDIOLOGY	0	0			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	SLEEP LAB	0	0			76.00
76.01	PAIN CLINIC	0	0			76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0	0			76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00	CLINIC	0	0			90.00
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
93.00	FAMILY PRACTICE	0	0			93.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part V
Date/Time Prepared:
3/11/2012 11:56 am

		Title XVIII		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	3.00	4.00		
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1.319291	0	308,681	0		50.00
53.00	ANESTHESIOLOGY	3.255707	0	10,895	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.686000	0	934,409	0		54.00
57.00	CT SCAN	0.000000	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	LABORATORY	0.354073	0	881,644	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
64.00	INTRAVENOUS THERAPY	0.287642	0	35,986	0		64.00
65.00	RESPIRATORY THERAPY	0.334922	0	67,603	0		65.00
66.00	PHYSICAL THERAPY	0.950733	0	571,531	0		66.00
67.00	OCCUPATIONAL THERAPY	1.003339	0	5,997	0		67.00
68.00	SPEECH PATHOLOGY	1.584176	0	3,223	0		68.00
69.00	ELECTROCARDIOLOGY	0.186879	0	67,978	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.573882	0	63,138	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.543233	0	51,289	10,135		73.00
76.00	SLEEP LAB	0.000000	0	0	0		76.00
76.01	PAIN CLINIC	0.000000	0	0	0		76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0.233228	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0.000000					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	2.305539	0	85,595	0		90.00
91.00	EMERGENCY	2.763942	0	372,666	7,168		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.094526	0	79,119	0		92.00
93.00	FAMILY PRACTICE	0.000000	0	0	0		93.00
200.00	Subtotal (see instructions)		0	3,539,754	17,303		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	3,539,754	17,303		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/11/2012 11:56 am
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Cost Center Description	Costs			Hospital	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	407,240	0		50.00
53.00 ANESTHESIOLOGY	0	35,471	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	641,005	0		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	312,166	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
64.00 INTRAVENOUS THERAPY	0	10,351	0		64.00
65.00 RESPIRATORY THERAPY	0	22,642	0		65.00
66.00 PHYSICAL THERAPY	0	543,373	0		66.00
67.00 OCCUPATIONAL THERAPY	0	6,017	0		67.00
68.00 SPEECH PATHOLOGY	0	5,106	0		68.00
69.00 ELECTROCARDIOLOGY	0	12,704	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	99,372	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	27,862	5,506		73.00
76.00 SLEEP LAB	0	0	0		76.00
76.01 PAIN CLINIC	0	0	0		76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	197,343	0		90.00
91.00 EMERGENCY	0	1,030,027	19,812		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	86,598	0		92.00
93.00 FAMILY PRACTICE	0	0	0		93.00
200.00 Subtotal (see instructions)	0	3,437,277	25,318		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	3,437,277	25,318		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141302

Period: From 10/01/2010

Worksheet D

Component CCN:14Z302

To 09/30/2011

Part V
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost	
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
						1.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1.319291	0	0	0	50.00
53.00	ANESTHESIOLOGY	3.255707	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.686000	0	0	0	54.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.354073	0	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0.287642	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.334922	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.950733	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	1.003339	0	0	0	67.00
68.00	SPEECH PATHOLOGY	1.584176	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.186879	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.573882	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.543233	0	0	0	73.00
76.00	SLEEP LAB	0.000000	0	0	0	76.00
76.01	PAIN CLINIC	0.000000	0	0	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0.233228	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	CLINIC	2.305539	0	0	0	90.00
91.00	EMERGENCY	2.763942	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.094526	0	0	0	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	0	93.00
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: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part V
Date/Time Prepared:
3/11/2012 11:56 am

Component CCN:142302

Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00 SLEEP LAB	0	0	0		76.00
76.01 PAIN CLINIC	0	0	0		76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 FAMILY PRACTICE	0	0	0		93.00
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/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302
Component CCN:146140

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	SLEEP LAB	0	0	0	0	0	76.00
76.01	PAIN CLINIC	0	0	0	0	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
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: 141302
Component CCN: 146140

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	843,710	0.000000	0.000000	0	50.00
53.00	ANESTHESIOLOGY	0	32,768	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,020,326	0.000000	0.000000	2,955	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	2,500,290	0.000000	0.000000	15,113	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	INTRAVENOUS THERAPY	0	590,877	0.000000	0.000000	184	64.00
65.00	RESPIRATORY THERAPY	0	326,912	0.000000	0.000000	0	65.00
66.00	PHYSICAL THERAPY	0	1,474,989	0.000000	0.000000	0	66.00
67.00	OCCUPATIONAL THERAPY	0	119,193	0.000000	0.000000	18,246	67.00
68.00	SPEECH PATHOLOGY	0	8,898	0.000000	0.000000	435	68.00
69.00	ELECTROCARDIOLOGY	0	146,373	0.000000	0.000000	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	181,696	0.000000	0.000000	45	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	718,130	0.000000	0.000000	48,576	73.00
76.00	SLEEP LAB	0	0	0.000000	0.000000	0	76.00
76.01	PAIN CLINIC	0	0	0.000000	0.000000	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0	85,856	0.000000	0.000000	48,960	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	1,174,577	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	109,806	0.000000	0.000000	339	90.00
91.00	EMERGENCY	0	809,463	0.000000	0.000000	3,074	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	124,093	0.000000	0.000000	462	92.00
93.00	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	12,267,957			138,389	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141302

Period: From 10/01/2010

Worksheet D

Component CCN: 146140

To 09/30/2011

Part IV
Date/Time Prepared: 3/11/2012 11:56 am

Title XVIII

Skilled Nursing Facility

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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 PAIN CLINIC	0	0	0	0	0	76.01
76.02 SNF PHYSICAL THERAPY - SCC THERAPY	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
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: 141302
Component CCN:146140

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		PSA Adj.	PSA Adj. All	Skilled Nursing Facility	PPS
		Allied Health	Other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0		50.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0		59.00
60.00	LABORATORY	0	0		60.00
60.01	BLOOD LABORATORY	0	0		60.01
64.00	INTRAVENOUS THERAPY	0	0		64.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	SLEEP LAB	0	0		76.00
76.01	PAIN CLINIC	0	0		76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0	0		76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	FAMILY PRACTICE	0	0		93.00
200.00	Total (lines 50-199)	0	0		200.00

Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,801 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			714 2.00
3.00	Private room days (excluding swing-bed and observation bed days)			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			714 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			289 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)			607 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			17 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)			174 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			531 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)			214 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)			644 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			120.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			125.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,690,553 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)			2,040 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)			21,750 25.00
26.00	Total swing-bed cost (see instructions)			1,507,898 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,182,655 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			981,788 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			981,788 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.204593 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,375.05 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)			1,182,655 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,656.37 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			879,532 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)			879,532 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141302		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 3/11/2012 11:56 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Cost 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)					420,233	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,299,765	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)					354,463	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,066,702	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,421,165	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)					82	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,656.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					135,823	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D-1

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description	Cost	Title XVIII		Hospital	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: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Component CCN:146140		Date/Time Prepared: 3/11/2012 11:56 am
		Title XVIII	Skilled Nursing Facility	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)		882	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		882	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		882	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)		0	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)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		597	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)		134,481	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)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		134,481	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)		134,481	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1	
		Component CCN: 146140		Date/Time Prepared: 3/11/2012 11:56 am	
		Title XVIII	Skilled Nursing Facility	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)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				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)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				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				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				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)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				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)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				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)				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)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				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)				134,481 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				152.47 71.00
72.00	Program routine service cost (line 9 x line 71)				91,025 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				91,025 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				91,025 83.00
84.00	Program inpatient ancillary services (see instructions)				74,089 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				165,114 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D-1

Component CCN: 146140

Date/Time Prepared:
3/11/2012 11:56 am

Title XVIII

Skilled Nursing
Facility

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	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet D-3

Date/Time Prepared:
3/11/2012 11:56 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		506,184		30.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	1.319291	578	763	50.00
53.00	ANESTHESIOLOGY	3.255707	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.686000	72,461	49,708	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.354073	185,968	65,846	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	0.287642	23,225	6,680	64.00
65.00	RESPIRATORY THERAPY	0.334922	107,540	36,018	65.00
66.00	PHYSICAL THERAPY	0.950733	17,905	17,023	66.00
67.00	OCCUPATIONAL THERAPY	1.003339	4,073	4,087	67.00
68.00	SPEECH PATHOLOGY	1.584176	528	836	68.00
69.00	ELECTROCARDIOLOGY	0.186879	10,146	1,896	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.573882	37,764	59,436	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.543233	156,467	84,998	73.00
76.00	SLEEP LAB	0.000000	0	0	76.00
76.01	PAIN CLINIC	0.000000	0	0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0.233228	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.305539	10	23	90.00
91.00	EMERGENCY	2.763942	33,219	91,815	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.094526	1,009	1,104	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		650,893	420,233	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)		650,893		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141302

Period:

worksheet D-3

Component CCN:14z302

From 10/01/2010

Date/Time Prepared:

To 09/30/2011

3/11/2012 11:56 am

Cost Center Description		Title XVIII		Swing Beds - SNF		Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
		1.00	2.00		3.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS			295,030			30.00
41.00	SUBPROVIDER - IRF			0			41.00
42.00	SUBPROVIDER			0			42.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1.319291		0		0	50.00
53.00	ANESTHESIOLOGY	3.255707		0		0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.686000		17,414		11,946	54.00
57.00	CT SCAN	0.000000		0		0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		0		0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000		0		0	59.00
60.00	LABORATORY	0.354073		57,873		20,491	60.00
60.01	BLOOD LABORATORY	0.000000		0		0	60.01
64.00	INTRAVENOUS THERAPY	0.287642		918		264	64.00
65.00	RESPIRATORY THERAPY	0.334922		52,583		17,611	65.00
66.00	PHYSICAL THERAPY	0.950733		155,835		148,157	66.00
67.00	OCCUPATIONAL THERAPY	1.003339		54,495		54,677	67.00
68.00	SPEECH PATHOLOGY	1.584176		1,817		2,878	68.00
69.00	ELECTROCARDIOLOGY	0.186879		1,184		221	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.573882		27,555		43,368	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		0		0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.543233		206,887		112,388	73.00
76.00	SLEEP LAB	0.000000		0		0	76.00
76.01	PAIN CLINIC	0.000000		0		0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0.233228		0		0	76.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	CLINIC	2.305539		273		629	90.00
91.00	EMERGENCY	2.763942		10,666		29,480	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.094526		0		0	92.00
93.00	FAMILY PRACTICE	0.000000		0		0	93.00
200.00	Total (sum of lines 50-94 and 96-98)			587,500		442,110	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0		0	201.00
202.00	Net Charges (line 200 minus line 201)			587,500			202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN:146140		Date/Time Prepared: 3/11/2012 11:56 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS			0	30.00
41.00	SUBPROVIDER - IRF			0	41.00
42.00	SUBPROVIDER			0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	1.319291		0	50.00
53.00	ANESTHESIOLOGY	3.255707		0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.686000	2,955	2,027	54.00
57.00	CT SCAN	0.000000		0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000		0	59.00
60.00	LABORATORY	0.354073	15,113	5,351	60.00
60.01	BLOOD LABORATORY	0.000000		0	60.01
64.00	INTRAVENOUS THERAPY	0.287642	184	53	64.00
65.00	RESPIRATORY THERAPY	0.334922		0	65.00
66.00	PHYSICAL THERAPY	0.950733		0	66.00
67.00	OCCUPATIONAL THERAPY	1.003339	18,246	18,307	67.00
68.00	SPEECH PATHOLOGY	1.584176	435	689	68.00
69.00	ELECTROCARDIOLOGY	0.186879		0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.573882	45	71	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.543233	48,576	26,388	73.00
76.00	SLEEP LAB	0.000000		0	76.00
76.01	PAIN CLINIC	0.000000		0	76.01
76.02	SNF PHYSICAL THERAPY - SCC THERAPY	0.233228	48,960	11,419	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.305539	339	782	90.00
91.00	EMERGENCY	2.763942	3,074	8,496	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.094526	462	506	92.00
93.00	FAMILY PRACTICE	0.000000		0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		138,389	74,089	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)		138,389		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/11/2012 11:56 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,462,595 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)		3,462,595	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)		3,497,221	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)		23,444	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		532,093	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,847,193	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,847,193	30.00
31.00	Primary payer payments		6,098	31.00
32.00	Subtotal (line 30 minus line 31)		2,841,095	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)		16,284	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		16,284	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,284	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,857,379	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,857,379	40.00
41.00	Interim payments		3,030,962	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)		-173,583	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet E
Part B
Date/Time Prepared:
3/11/2012 11:56 am

Title XVIII

Hospital

Cost

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 override of Ancillary service charges (line 12)

0 112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/11/2012 11:56 am
		Component CCN:146140		
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)			0 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)			0 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)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			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)			0 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)			0 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			0 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			0 37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)			0 40.00
41.00	Interim payments			0 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)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141302 Component CCN: 146140	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/11/2012 11:56 am	PPS
Title XVIII	Skilled Nursing Facility	Overrides	
WORKSHEET OVERRIDE VALUES		1.00	
112.00 Override of Ancillary service charges (line 12)	0		112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
3/11/2012 11:56 am

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,497,092		3,039,799	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		-7,435	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	04/22/2011	80,023	04/22/2011	130,327	3.01
3.02		09/09/2011	38,443		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	09/09/2011	131,729	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)		118,466		-1,402	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)		1,615,558		3,030,962	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		458,147		173,583	6.02
7.00	Total Medicare program liability (see instructions)		1,157,411		2,857,379	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: 141302

Period: From 10/01/2010 To 09/30/2011

Worksheet E-1 Part I

Component CCN: 142302

Date/Time Prepared: 3/11/2012 11:56 am

		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					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		2,240,584			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	04/22/2011	220,770			0	3.01
3.02		09/22/2011	121,096			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)		341,866			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)		2,582,450			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		0			0	6.01
6.02	SETTLEMENT TO PROGRAM		724,005			0	6.02
7.00	Total Medicare program liability (see instructions)		1,858,445			0	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: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
3/11/2012 11:56 am

Component CCN:146140

Title XVIII

Skilled Nursing
Facility

PPS

		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		136,640		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		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)		0		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)		136,640		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		136,640		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: 141302

Period:

Worksheet E-2

Component CCN: 142302

From 10/01/2010

Date/Time Prepared:

To 09/30/2011

3/11/2012 11:56 am

		Title XVIII		Swing Beds - SNF	Cost	
				Part A	Part B	
				1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES						
1.00	Inpatient routine services - swing bed-SNF (see instructions)			1,435,377	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)			446,531	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			858	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)			1,881,908	0	8.00
9.00	Primary payer payments (see instructions)			0	0	9.00
10.00	Subtotal (line 8 minus line 9)			1,881,908	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)			1,881,908	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			23,463	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)			1,858,445	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	16.00
17.00	Reimbursable bad debts (see instructions)			0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)			1,858,445	0	19.00
20.00	Interim payments			2,582,450	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)			-724,005	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet E-3
Part V
Date/Time Prepared:
3/11/2012 11:56 am

		Title XVIII	Hospital	Cost		
					1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)						
1.00	Inpatient services			1,299,765	1.00	
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0	2.00	
3.00	Organ acquisition			0	3.00	
4.00	Subtotal (sum of lines 1 thru 3)			1,299,765	4.00	
5.00	Primary payer payments			0	5.00	
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			1,312,763	6.00	
COMPUTATION OF LESSER OF COST OR CHARGES						
Reasonable charges						
7.00	Routine service charges			0	7.00	
8.00	Ancillary service charges			0	8.00	
9.00	Organ acquisition charges, net of revenue			0	9.00	
10.00	Total reasonable charges			0	10.00	
Customary charges						
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	11.00	
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0	12.00	
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00	
14.00	Total customary charges (see instructions)			0	14.00	
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0	15.00	
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0	16.00	
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0	17.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0	18.00	
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,312,763	19.00	
20.00	Deductibles (exclude professional component)			156,484	20.00	
21.00	Excess reasonable cost (from line 16)			0	21.00	
22.00	Subtotal (line 19 minus line 20)			1,156,279	22.00	
23.00	Coinsurance			0	23.00	
24.00	Subtotal (line 22 minus line 23)			1,156,279	24.00	
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,132	25.00	
26.00	Adjusted reimbursable bad debts (see instructions)			1,132	26.00	
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,132	27.00	
28.00	Subtotal (sum of lines 24 and 25 or 26)			1,157,411	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)			1,157,411	30.00	
31.00	Interim payments			1,615,558	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)			-458,147	33.00	
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0	34.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141302 Component CCN:146140	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VI Date/Time Prepared: 3/11/2012 11:56 am
	Title XVIII	Skilled Nursing Facility	PPS
			1.00

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)	188,981	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	188,981	4.00
COMPUTATION OF NET COST OF COVERED SERVICES			
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of w/s E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	52,341	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	136,640	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)	136,640	15.00
16.00	Interim payments	136,640	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

worksheet G

Date/Time Prepared:
3/11/2012 11:56 am

	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	1,629,875	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	3,347,405	0	0	0 4.00
5.00	Other receivable	0	0	0	0 5.00
6.00	Allowances for uncollectible notes and accounts receivable	-771,300	0	0	0 6.00
7.00	Inventory	285,077	0	0	0 7.00
8.00	Prepaid expenses	4,465	0	0	0 8.00
9.00	Other current assets	0	0	0	0 9.00
10.00	Due from other funds	1,535,119	0	0	0 10.00
11.00	Total current assets (sum of lines 1-10)	6,030,641	0	0	0 11.00
FIXED ASSETS					
12.00	Land	559,916	0	0	0 12.00
13.00	Land improvements	3,708,516	0	0	0 13.00
14.00	Accumulated depreciation	-1,091,815	0	0	0 14.00
15.00	Buildings	38,933,644	0	0	0 15.00
16.00	Accumulated depreciation	-9,907,811	0	0	0 16.00
17.00	Leasehold improvements	0	0	0	0 17.00
18.00	Accumulated depreciation	0	0	0	0 18.00
19.00	Fixed equipment	0	0	0	0 19.00
20.00	Accumulated depreciation	0	0	0	0 20.00
21.00	Automobiles and trucks	0	0	0	0 21.00
22.00	Accumulated depreciation	0	0	0	0 22.00
23.00	Major movable equipment	9,036,552	0	0	0 23.00
24.00	Accumulated depreciation	-6,040,804	0	0	0 24.00
25.00	Minor equipment depreciable	0	0	0	0 25.00
26.00	Accumulated depreciation	0	0	0	0 26.00
27.00	HIT designated Assets	0	0	0	0 27.00
28.00	Accumulated depreciation	0	0	0	0 28.00
29.00	Minor equipment-nondepreciable	36,153	0	0	0 29.00
30.00	Total fixed assets (sum of lines 12-29)	35,234,351	0	0	0 30.00
OTHER ASSETS					
31.00	Investments	5,920,543	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	856,024	0	0	0 34.00
35.00	Total other assets (sum of lines 31-34)	6,776,567	0	0	0 35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,041,559	0	0	0 36.00
CURRENT LIABILITIES					
37.00	Accounts payable	623,154	0	0	0 37.00
38.00	Salaries, wages, and fees payable	454,174	0	0	0 38.00
39.00	Payroll taxes payable	25,670	0	0	0 39.00
40.00	Notes and loans payable (short term)	350,000	0	0	0 40.00
41.00	Deferred income	90,050	0	0	0 41.00
42.00	Accelerated payments	0	0	0	0 42.00
43.00	Due to other funds	0	0	0	0 43.00
44.00	Other current liabilities	2,870,119	0	0	0 44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,413,167	0	0	0 45.00
LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0 46.00
47.00	Notes payable	45,135,000	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)	45,135,000	0	0	0 50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,548,167	0	0	0 51.00
CAPITAL ACCOUNTS					
52.00	General fund balance	-1,506,608	0	0	0 52.00
53.00	Specific purpose fund	0	0	0	0 53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0 54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0 55.00
56.00	Governing body created - endowment fund balance	0	0	0	0 56.00
57.00	Plant fund balance - invested in plant	0	0	0	0 57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0 58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-1,506,608	0	0	0 59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,041,559	0	0	0 60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
3/11/2012 11:56 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		107,727		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		-1,919,458			2.00
3.00 Total (sum of line 1 and line 2)		-1,811,731		0	3.00
4.00 Additions (credit adjustments) (specify)	0		0		4.00
5.00 RESTRICTED INVESTMENT INCOME	4,042		0		5.00
6.00 PY ADJUSTMENT FOR PRELIM MCR	301,081		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)		305,123		0	10.00
11.00 Subtotal (line 3 plus line 10)		-1,506,608		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)		-1,506,608		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
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		Endowment Fund		Plant Fund		
		5.00	6.00	7.00	8.00	
		1.00	Fund balances at beginning of period		0	
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	RESTRICTED INVESTMENT INCOME	0		0		5.00
6.00	PY ADJUSTMENT FOR PRELIM MCR	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

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	613,204		613,204	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	338,884		338,884	5.00
6.00	Swing bed - NF	29,700		29,700	6.00
7.00	SKILLED NURSING FACILITY	302,526		302,526	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	3,182,948		3,182,948	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,467,262		4,467,262	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)	4,467,262		4,467,262	17.00
18.00	Ancillary services	1,741,116	0	1,741,116	18.00
19.00	Outpatient services	0	9,352,264	9,352,264	19.00
20.00	RURAL HEALTH CLINIC	0	1,174,577	1,174,577	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
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	PROFESSIONAL FEES	0	1,621,635	1,621,635	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	6,208,378	12,148,476	18,356,854	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		18,210,301		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR BAD DEBTS	487,147			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)		487,147		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		18,697,448		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141302

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-3

Date/Time Prepared:
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		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	18,356,854	1.00
2.00	Less contractual allowances and discounts on patients' accounts	3,075,434	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,281,420	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	18,697,448	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,416,028	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	21,443	6.00
7.00	Income from investments	103,883	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	212,463	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	2,221	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	5,493	22.00
23.00	Governmental appropriations	17,166	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	ASSISTED LIVING UNITS	656,654	24.01
24.02	ADULT DAY CARE PROGRAM	280,543	24.02
24.03	FITNESS CENTER REVENUE	128,504	24.03
24.04	GRANT REVENUE	43,309	24.04
24.05	MASSAGE THERAPY REVENUE	7,448	24.05
24.06	FOOD GRANT REVENUE	21,146	24.06
25.00	Total other income (sum of lines 6-24)	1,500,273	25.00
26.00	Total (line 5 plus line 25)	-1,915,755	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	LOSS ON DISPOSAL OF ASSETS	3,703	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	3,703	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,919,458	29.00

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

Provider CCN: 141302
Component CCN:148511

Period:
From 10/01/2010
To 09/30/2011

Worksheet M-1

Date/Time Prepared:
3/11/2012 11:56 am

		Title XVIII			Rural Health Clinic (RHC) I	Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	463,712	45,000	508,712	33,052	541,764	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	68,090	0	68,090	-13,929	54,161	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	140,203	0	140,203	0	140,203	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	672,005	45,000	717,005	19,123	736,128	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	14,643	14,643	0	14,643	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	14,643	14,643	0	14,643	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	672,005	59,643	731,648	19,123	750,771	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
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	121,572	97,399	218,971	-7,369	211,602	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	121,572	97,399	218,971	-7,369	211,602	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	793,577	157,042	950,619	11,754	962,373	32.00

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

Provider CCN: 141302
Component CCN:148511

Period:
From 10/01/2010
To 09/30/2011

Worksheet M-1

Date/Time Prepared:
3/11/2012 11:56 am

		Title XVIII		Rural Health Clinic (RHC) I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	541,764		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	54,161		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	140,203		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	736,128		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	14,643		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	14,643		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	750,771		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
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	211,602		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	211,602		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	962,373		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	worksheet M-2		
		Component CCN:148511		Date/Time Prepared: 3/11/2012 11:56 am		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.58	5,694	4,200	6,636	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.46	1,250	2,100	966	3.00
4.00	Subtotal (sum of lines 1-3)	2.04	6,944		7,602	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)	2.04	6,944		7,602	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)				750,771	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)				750,771	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)				211,602	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				951,087	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,162,689	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				1,162,689	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				1,162,689	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,913,460	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	worksheet M-3
		Component CCN:148511		Date/Time Prepared: 3/11/2012 11:56 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from worksheet M-2, line 20)		1,913,460	1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)		7,843	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,905,617	3.00
4.00	Total Visits (from worksheet M-2, column 5, line 8)		7,602	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)		7,602	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		250.67	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)		71.45	71.45 8.00
9.00	Rate for Program covered visits (see instructions)		250.67	250.67 9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)		0	711 10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	178,226 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	178,226 16.00
16.01	Total program charges (see instructions)(from contractor's records)			0 16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0 16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0 16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			138,304 16.04
16.05	Total program cost (see instructions)		0	138,304 16.05
17.00	Primary payer amounts			0 17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			5,346 18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			23,982 19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			138,304 20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)			4,262 21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			142,566 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)			142,566 26.00
27.00	Interim payments			23,600 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)			118,966 29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2			0 30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141302	Period: From 10/01/2010 To 09/30/2011	Worksheet M-4
		Component CCN:148511		Date/Time Prepared: 3/11/2012 11:56 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from worksheet M-1, column 7, line 10)	736,128	736,128	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000147	0.000780	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	108	574	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,042	1,353	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,150	1,927	5.00
6.00	Total direct cost of the facility (from worksheet M-1, column 7, line 22)	750,771	750,771	6.00
7.00	Total overhead (from worksheet M-2, line 16)	1,162,689	1,162,689	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001532	0.002567	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,781	2,985	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,931	4,912	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	20	106	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	146.55	46.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	73	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	879	3,383	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)		7,843	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to worksheet M-3, line 21)		4,262	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141302 Component CCN:148511	Period: From 10/01/2010 To 09/30/2011	Worksheet M-5 Date/Time Prepared: 3/11/2012 11:56 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		23,600	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)		23,600	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		118,966	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		142,566	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00