

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: 141348	Period: From 07/01/2010 To 06/30/2011	worksheet S Parts I-III Date/Time Prepared: 1/30/2012 3:41 pm
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report Date: 1/30/2012 Time: 3:41 pm

2. Manually submitted cost report

3. If this is an amended report enter the number of times the provider resubmitted this cost report

4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. 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. Initial Report for this Provider CCN

9. Final Report for this Provider CCN

10. NPR Date:

11. Contractor's Vendor Code: 4

12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

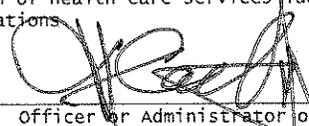
CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RED BUD REGIONAL HOSPITAL for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 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.

Encryption Information

ECR: Date: 1/30/2012 Time: 3:41 pm
p913ovU:Rlz8qY.doX.jlEyQvKLYk0
n5VB10zgPFghGLSDv8FQhaTDPImEWH
9dg10swxN70u8KSc

PI: Date: 1/30/2012 Time: 3:41 pm
BEF3zYc1wvXILifyeUD:7..D.VoLX0
WTPqL0N1hE5qrsAqF21un:68kvB7u1
ZYkhFNppCA0q1TZY

(Signed) 
Officer or Administrator of Provider(s)
Senior Vice President, Revenue Management
Title
1-31-12
Date

	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	145,797	-501,250	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	185,292	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	34,897	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	331,089	-466,353	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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 1/30/2012 3:41 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report	Date: 1/30/2012	Time: 3:41 pm
	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.		
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

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(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	145,797	-501,250	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	185,292	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	34,897	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	331,089	-466,353	0	0	200.00

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FORM APPROVED
OMB NO. 0938-0050

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PART I - COST REPORT STATUS

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	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.		
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.

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Encryption Information
 ECR: Date: 1/30/2012 Time: 3:41 pm
 p9I3oVu:R1z8qY.doX.jlEyQvKLYk0
 n5VB10zgPFghGLsdv8FQhaTDPImEWH
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 PI: Date: 1/30/2012 Time: 3:41 pm
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 WTPqLON1he5qrsAqF21un:68kvB7u1
 ZYkhFNppCA0q1TzY

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

 Title

 Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	145,797	-501,250	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	185,292	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	34,897	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	331,089	-466,353	0	0	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/30/2012 12:55 pm
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1.00	Hospital and Hospital Health Care Complex Address:		2.00	3.00	4.00
1.00	Street: ST. CLEMENT BLVD	PO Box:	2.00	Zip Code: 62278-	1.00
2.00	City: RED BUD	State: IL	2.00	County: RANDOLPH	2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	RED BUD REGIONAL HOSPITAL	141348	99914	1	07/01/2005	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	RED BUD HOSPITAL	142348	99914		08/10/2005	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA						N	N	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	OLDER ADULT HEALTH CENTER	148514	99914		05/26/2011	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

20.00	Cost Reporting Period (mm/dd/yyyy)	From: 07/01/2010	To: 06/30/2011	20.00
21.00	Type of Control (see instructions)	4		21.00

Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					3		N		23.00

	In-State Medicaid paid days	In-State Medicaid eligible 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	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	25.00

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.	1.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/30/2012 12:55 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
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		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1 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: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-2
Part I
Date/Time Prepared:
1/30/2012 12:55 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/(col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1 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
70.00	Inpatient Psychiatric Facility PPS 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
75.00	Inpatient Rehabilitation Facility PPS 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
80.00	Long Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.					N	80.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	worksheet S-2 Part I Date/Time Prepared: 1/30/2012 12:55 pm	
				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)(ii)? Enter "Y" for yes and "N" for no.		N		86.00
		V		XIX	
		1.00		2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
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.		100,000,000	100,000,000	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.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	worksheet S-2 Part I Date/Time Prepared: 1/30/2012 12:55 pm			
			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)		Y	449008		140.00	
	1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: CHS / COMMUNITY HEALTH SYSTEMS, INC.		Contractor's Name: WPS		Contractor's Number: 52280		
142.00	Street: 4000 MERIDIAN BLVD		PO Box:		142.00		
143.00	City: FRANKLIN		State: TN		Zip Code: 37067		
			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				
			2.00				
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
			Part A		Part B		
			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		N	N		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	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	166.00
			1.00				
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						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)					0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/30/2012 12:55 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "i" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/27/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	worksheet S-2 Part II Date/Time Prepared: 1/30/2012 12:55 pm
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	Description	Part A			
		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 amendmets to existing leases entered into during this cost reporting period? If yes, see instructions	N			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N			25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N			27.00

Interest Expense

28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N			31.00

Purchased Services

32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N			33.00

Provider-Based Physicians

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

Y/N	Date
1.00	2.00

Home Office Costs

36.00	were home office costs claimed on the cost report?	Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2010		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/30/2012 12:55 pm
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		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/27/2011	16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet S-3
Part I
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	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	66,375.00	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	66,375.00	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	66,375.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		17.00
18.00 SUBPROVIDER	42.00	0	0		18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
25.10 CMHC - CORF	99.10				25.10
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 Observation Bed Days					28.00
28.02 SUBPROVIDER - IRF	41.00				28.02
28.03 SUBPROVIDER	42.00				28.03
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

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	2,144	135	2,817	1.00	
2.00 HMO		288	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	2,754	0	2,754	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	361	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	4,898	135	5,932	7.00	
8.00 INTENSIVE CARE UNIT					8.00	
9.00 CORONARY CARE UNIT					9.00	
10.00 BURN INTENSIVE CARE UNIT					10.00	
11.00 SURGICAL INTENSIVE CARE UNIT					11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00	
13.00 NURSERY					13.00	
14.00 Total (see instructions)	0	4,898	135	5,932	14.00	
15.00 CAH visits	0	3,319	0	4,361	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF	0	0	0	0	17.00	
18.00 SUBPROVIDER	0	0	0	0	18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY	0	0	0	0	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
25.10 CMHC - CORF	0	0	0	0	25.10	
26.00 RURAL HEALTH CLINIC	0	483	0	642	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	192	28.00	
28.02 SUBPROVIDER - IRF	0	0	0	0	28.02	
28.03 SUBPROVIDER	0	0	0	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	

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	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	596	1.00
2.00 HMO					52	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	142.70	0.00	0	596	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	2.58	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	145.28	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	77	860		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)	77	860		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/30/2012 12:55 pm
			Rural Health Clinic (RHC) I	Cost
			1.00	
Clinic Address and Identification				
1.00	Street	325 SPRING ST		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	RED BUD	IL	62278
				1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
			Grant Award	Date
			1.00	2.00
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)			0
5.00	Migrant Health Center (Section 329(d), PHS Act)			0
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0
7.00	Appalachian Regional Commission			0
8.00	Look-Alikes			0
9.00	OTHER (SPECIFY)			0
			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.)			0
		Sunday	Monday	
		from	to	from
		1.00	2.00	3.00
		4.00		
Facility hours of operations (1)				
11.00	Clinic	09:00	05:00	11.00
			1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?			Y
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
			1.00	2.00
		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	OLDER ADULT HEALTH CENTER	141348	14.00
		Y/N	V	XVIII
		1.00	2.00	3.00
				4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)	N	0	0
				0
				15.00

Health Financial Systems		In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141348 Component CCN:148514	Period: From 07/01/2010 to 06/30/2011	worksheet S-8 Date/Time Prepared: 1/30/2012 12:55 pm	
		Rural Health Clinic (RHC) I		Cost	
		County			
		4.00			
2.00	City, State, Zip Code, County	RED BUD		2.00	
		Tuesday		wednesday	
		from	to	from	to
		5.00	6.00	7.00	8.00
11.00	Facility hours of operations (1) Clinic	09:00	05:00	09:00	05:00
				11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2010 To 06/30/2011	worksheet S-8 Date/Time Prepared: 1/30/2012 12:55 pm		
		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	09:00	05:00	09:00	05:00	11.00

Health Financial Systems

In Lieu of Form CMS-2552-10

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2010 To 06/30/2011	worksheet S-8 Date/Time Prepared: 1/30/2012 12:55 pm
			Rural Health Clinic (RHC) I	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			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)	0.199259	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	633,305	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	497,128	5.00
6.00	Medicaid charges	6,768,817	6.00
7.00	Medicaid cost (line 1 times line 6)	1,348,748	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)	218,315	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	53,202	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	218,315	19.00
		Uninsured patients	Insured patients
		1.00	2.00
			Total (col. 1 + col. 2)
			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	110,691	20,451
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	22,056	4,075
22.00	Partial payment by patients approved for charity care	360	0
23.00	Cost of charity care (line 21 minus line 22)	21,696	4,075
			1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	560,513	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	433,189	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	127,324	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	25,370	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	51,141	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	269,456	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet A

Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		187,000	187,000	51,301	238,301	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		648,111	648,111	192,868	840,979	2.00
4.00 EMPLOYEE BENEFITS	115,286	68,625	183,911	1,030,977	1,214,888	4.00
5.00 ADMINISTRATIVE & GENERAL	1,848,293	6,858,432	8,706,725	-2,350,435	6,356,290	5.00
7.00 OPERATION OF PLANT	231,268	791,785	1,023,053	-66,007	957,046	7.00
8.00 LAUNDRY & LINEN SERVICE	0	109,982	109,982	0	109,982	8.00
9.00 HOUSEKEEPING	153,850	40,868	194,718	-11,835	182,883	9.00
10.00 DIETARY	0	948,148	948,148	-198,799	749,349	10.00
11.00 CAFETERIA	0	0	0	198,799	198,799	11.00
13.00 NURSING ADMINISTRATION	637,149	72,423	709,572	-24,595	684,977	13.00
14.00 CENTRAL SERVICES & SUPPLY	35,842	217,493	253,335	-174,016	79,319	14.00
15.00 PHARMACY	222,066	671,956	894,022	-546,590	347,432	15.00
16.00 MEDICAL RECORDS & LIBRARY	188,951	165,152	354,103	-9,978	344,125	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,169,240	390,055	1,559,295	-21,809	1,537,486	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	398,327	145,061	543,388	-11,713	531,675	50.00
53.00 ANESTHESIOLOGY	368,699	60,511	429,210	-3,717	425,493	53.00
54.00 RADIOLOGY-DIAGNOSTIC	630,313	741,994	1,372,307	-86,946	1,285,361	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	358,630	644,144	1,002,774	-13,600	989,174	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	171,950	53,195	225,145	-31,969	193,176	65.00
66.00 PHYSICAL THERAPY	336,542	33,021	369,563	0	369,563	66.00
67.00 OCCUPATIONAL THERAPY	76,243	7,074	83,317	0	83,317	67.00
68.00 SPEECH PATHOLOGY	0	48,966	48,966	0	48,966	68.00
69.00 ELECTROCARDIOLOGY	28,476	80,831	109,307	0	109,307	69.00
70.10 CARDIAC REHAB	0	0	0	0	0	70.10
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	170,078	170,078	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,874	22,874	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	527,353	527,353	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	251,625	53,945	305,570	-232,786	72,784	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	944,952	185,022	1,129,974	928,498	2,058,472	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
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
118.00 SUBTOTALS (SUM OF LINES 1-117)	8,167,702	13,223,794	21,391,496	-662,047	20,729,449	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	-69,654	-69,654	4,885	-64,769	192.00
194.00 HOME HEALTH	0	0	0	0	0	194.00
194.01 MARKETING	0	0	0	114,324	114,324	194.01
194.02 SENIOR CIRCLE	7,506	2	7,508	2,796	10,304	194.02
194.03 RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04 WATERLOO SPECIALTY CLINIC	0	59,924	59,924	0	59,924	194.04
194.05 FREE STANDING NURSING HOME	0	0	0	232,969	232,969	194.05
194.06 CLINIC CORPORATION	0	0	0	307,073	307,073	194.06
200.00 TOTAL (SUM OF LINES 118-199)	8,175,208	13,214,066	21,389,274	0	21,389,274	200.00

Cost Center Description		Adjustments	Net Expenses	
		(See A-8)	For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	204,867	443,168	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	147,915	988,894	2.00
4.00	EMPLOYEE BENEFITS	-15,438	1,199,450	4.00
5.00	ADMINISTRATIVE & GENERAL	-3,509,853	2,846,437	5.00
7.00	OPERATION OF PLANT	0	957,046	7.00
8.00	LAUNDRY & LINEN SERVICE	0	109,982	8.00
9.00	HOUSEKEEPING	0	182,883	9.00
10.00	DIETARY	413,103	1,162,452	10.00
11.00	CAFETERIA	-109,169	89,630	11.00
13.00	NURSING ADMINISTRATION	-462	684,515	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	79,319	14.00
15.00	PHARMACY	0	347,432	15.00
16.00	MEDICAL RECORDS & LIBRARY	-20	344,105	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,537,486	30.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	531,675	50.00
53.00	ANESTHESIOLOGY	-465,317	-39,824	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-1,370	1,283,991	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	989,174	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	0	193,176	65.00
66.00	PHYSICAL THERAPY	0	369,563	66.00
67.00	OCCUPATIONAL THERAPY	0	83,317	67.00
68.00	SPEECH PATHOLOGY	0	48,966	68.00
69.00	ELECTROCARDIOLOGY	-12,370	96,937	69.00
70.10	CARDIAC REHAB	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	170,078	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	22,874	72.00
73.00	DRUGS CHARGED TO PATIENTS	-4,761	522,592	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-17	72,767	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	-540,903	1,517,569	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORP	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	101.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	-3,893,795	16,835,654	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	83,055	18,286	192.00
194.00	HOME HEALTH	0	0	194.00
194.01	MARKETING	0	114,324	194.01
194.02	SENIOR CIRCLE	-850	9,454	194.02
194.03	RED BUD SPECIALTY CLINIC	0	0	194.03
194.04	WATERLOO SPECIALTY CLINIC	-357	59,567	194.04
194.05	FREE STANDING NURSING HOME	0	232,969	194.05
194.06	CLINIC CORPORATION	0	307,073	194.06
200.00	TOTAL (SUM OF LINES 118-199)	-3,811,947	17,577,327	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	1,107,036	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	1,107,036	
B - RECLASS OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	22,398	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	22,398	
C - RECLASS RENTS AND LEASES					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	205,243	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	205,243	
D - RECLASS OTHER CAPITAL					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	53,857	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,926	2.00
	TOTALS		0	57,783	
E - RECLASS MARKETING COSTS					
1.00	MARKETING	194.01	37,959	76,365	1.00
	TOTALS		37,959	76,365	
F - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	147,680	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	22,874	2.00
	TOTALS		0	170,554	
G - RECLASS CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	527,353	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	527,353	
H - RECLASS NURSING HOME SERVICES					
1.00	FREE STANDING NURSING HOME	194.05	183,272	49,697	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		183,272	49,697	
I - RECLASS CLINIC CORPORATION SERVICES					
1.00	CLINIC CORPORATION	194.06	51,970	11,721	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		51,970	11,721	
J - RECLASS ER PHYSICIAN COSTS					
1.00	EMERGENCY	91.00	561,430	374,196	1.00
	TOTALS		561,430	374,196	
K - DIRECTLY ALLOCATED DEPRECIATION					
1.00	CLINIC CORPORATION	194.06	0	13,265	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,796	2.00
3.00	SENIOR CIRCLE	194.02	0	2,796	3.00
	TOTALS		0	18,857	
L - RECLASS DIETARY COST TO CAFETERIA					
1.00	CAFETERIA	11.00	0	198,799	1.00
	TOTALS		0	198,799	
M - RECLASS RHC ACTIVITY TO CLINIC CORP					
1.00	CLINIC CORPORATION	194.06	190,683	39,434	1.00
	TOTALS		190,683	39,434	

RECLASSIFICATIONS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet A-6

Date/Time Prepared:
1/30/2012 12:55 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
N - RECLASS RHC RENTAL INCOME						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00		0	2,089	1.00
	TOTALS			0	2,089	
500.00	Grand Total: Increases			1,025,314	2,861,525	500.00

	Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,106,566	0	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	470	0	2.00
	TOTALS		0	1,107,036		
B - RECLASS OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	615	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	674	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	21,109	0	3.00
	TOTALS		0	22,398		
C - RECLASS RENTS AND LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,938	10	1.00
2.00	OPERATION OF PLANT	7.00	0	329	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	152	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,596	0	4.00
5.00	PHARMACY	15.00	0	22,112	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,531	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	21,809	0	7.00
8.00	OPERATING ROOM	50.00	0	3,964	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	168	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	86,946	0	10.00
11.00	LABORATORY	60.00	0	13,600	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	10,860	0	12.00
13.00	RURAL HEALTH CLINIC	88.00	0	110	0	13.00
14.00	EMERGENCY	91.00	0	7,128	0	14.00
	TOTALS		0	205,243		
D - RECLASS OTHER CAPITAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,783	14	1.00
2.00		0.00	0	0	14	2.00
	TOTALS		0	57,783		
E - RECLASS MARKETING COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	37,959	76,365	0	1.00
	TOTALS		37,959	76,365		
F - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	163,420	0	1.00
2.00	OPERATING ROOM	50.00	0	7,134	0	2.00
	TOTALS		0	170,554		
G - RECLASS CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	524,478	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	2,875	0	2.00
	TOTALS		0	527,353		
H - RECLASS NURSING HOME SERVICES						
1.00	EMPLOYEE BENEFITS	4.00	34,208	18,711	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	64,526	8,450	0	2.00
3.00	OPERATION OF PLANT	7.00	43,705	21,973	0	3.00
4.00	HOUSEKEEPING	9.00	11,835	0	0	4.00
5.00	NURSING ADMINISTRATION	13.00	23,551	563	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	5,447	0	0	6.00
	TOTALS		183,272	49,697		
I - RECLASS CLINIC CORPORATION SERVICES						
1.00	EMPLOYEE BENEFITS	4.00	14,958	8,182	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	36,929	3,293	0	2.00
3.00	NURSING ADMINISTRATION	13.00	83	246	0	3.00
	TOTALS		51,970	11,721		
J - RECLASS ER PHYSICIAN COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	561,430	374,196	0	1.00
	TOTALS		561,430	374,196		
K - DIRECTLY ALLOCATED DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,556	9	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	16,301	9	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	18,857		
L - RECLASS DIETARY COST TO CAFETERIA						
1.00	DIETARY	10.00	0	198,799	0	1.00
	TOTALS		0	198,799		
M - RECLASS RHC ACTIVITY TO CLINIC CORP.						
1.00	RURAL HEALTH CLINIC	88.00	190,683	39,434	0	1.00
	TOTALS		190,683	39,434		
N - RECLASS RHC RENTAL INCOME						
1.00	RURAL HEALTH CLINIC	88.00	0	2,089	0	1.00
	TOTALS		0	2,089		
500.00	Grand Total: Decreases		1,025,314	2,861,525		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2012 12:55 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	55,767	0	0	0	2.00
3.00	Buildings and Fixtures	75,067	20,602	0	20,602	3.00
4.00	Building Improvements	5,951,299	931,039	0	931,039	4.00
5.00	Fixed Equipment	679,820	131,800	0	131,800	5.00
6.00	Movable Equipment	10,494,517	829,439	0	829,439	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,256,470	1,912,880	0	1,912,880	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,256,470	1,912,880	0	1,912,880	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	187,000	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	648,111	0	0	0	2.00
3.00	Total (sum of lines 1-2)	835,111	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	6,354,062	0	6,354,062	0.350847	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	11,756,582	0	11,756,582	0.649153	2.00
3.00	Total (sum of lines 1-2)	18,110,644	0	18,110,644	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2012 12:55 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0		1.00		
2.00	Land Improvements	55,767	0		2.00		
3.00	Buildings and Fixtures	95,669	0		3.00		
4.00	Building Improvements	6,202,626	0		4.00		
5.00	Fixed Equipment	802,327	0		5.00		
6.00	Movable Equipment	10,954,255	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	18,110,644	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	18,110,644	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	187,000		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	648,111		2.00		
3.00	Total (sum of lines 1-2)	0	835,111		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	0	372,642	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	737,409	205,243	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,110,051	205,243	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2012 12:55 pm

SUMMARY OF CAPITAL

Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	0	70,526	443,168	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	46,242	988,894	2.00
3.00 Total (sum of lines 1-2)	0	0	0	116,768	1,432,062	3.00

		Expense Classification on worksheet A To/From which the Amount is to be Adjusted			
	Basis/Code (2)	Amount	Cost Center	Line #	
	1.00	2.00	3.00	4.00	
1.00	Investment income - buildings and fixtures (chapter 2)		0NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)		0NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A -11,247	ADMINISTRATIVE & GENERAL	5.00	7.00
8.00	Television and radio service (chapter 21)	A -375	NEW CAP REL COSTS-MVBLE EQUIP	2.00	8.00
9.00	Parking lot (chapter 21)	0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2 -555,673			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B -1,370	RADIOLOGY-DIAGNOSTIC	54.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1 -1,641,586			12.00
13.00	Laundry and linen service	0		0.00	13.00
14.00	Cafeteria-employees and guests	B -109,169	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others	0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients	0		0.00	16.00
17.00	Sale of drugs to other than patients	B -4,761	DRUGS CHARGED TO PATIENTS	73.00	17.00
18.00	Sale of medical records and abstracts	B -20	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		0.00	19.00
20.00	Vending machines	B -50	ADMINISTRATIVE & GENERAL	5.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B -32,398	ADMINISTRATIVE & GENERAL	5.00	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 - buildings and fixtures	A 168,669	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment	A 109,444	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist	0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant	0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3 0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3 0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		0.00	32.00
33.00	FEES FROM INSERVICE EDUCATION	B -160	NURSING ADMINISTRATION	13.00	33.00
34.00	FITNESS REVENUE	B -990	ADMINISTRATIVE & GENERAL	5.00	34.00
35.00	RENTAL INCOME - SBC & RB SPEC CLINIC	B -41,721	NEW CAP REL COSTS-BLDG & FIXT	1.00	35.00
36.00	OTHER MISC REVENUE	B -1,629	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	HOSPITAL BAD DEBT	A -1,245,833	ADMINISTRATIVE & GENERAL	5.00	37.00
38.00	TELEPHONE SERVICES	A -626	EMPLOYEE BENEFITS	4.00	38.00
38.01	TELEPHONE SERVICES	A -302	NURSING ADMINISTRATION	13.00	38.01
38.02	TELEPHONE SERVICES	A -17	RURAL HEALTH CLINIC	88.00	38.02
38.03	TELEPHONE SERVICES	A -357	WATERLOO SPECIALTY CLINIC	194.04	38.03
38.04	TELEPHONE DEPRECIATION	A -3,470	NEW CAP REL COSTS-MVBLE EQUIP	2.00	38.04
39.00	ADVERTISING	A -14,812	EMPLOYEE BENEFITS	4.00	39.00
39.01	ADVERTISING	A -64,843	ADMINISTRATIVE & GENERAL	5.00	39.01
40.00	CLUB DUES AND LOBBYING	A -500	ADMINISTRATIVE & GENERAL	5.00	40.00
41.00	PHYSICIAN RECRUITING	A -161,519	ADMINISTRATIVE & GENERAL	5.00	41.00
42.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A -8,844	ADMINISTRATIVE & GENERAL	5.00	42.00
43.00	ALCOHOLIC BEVERAGES	A -1,120	ADMINISTRATIVE & GENERAL	5.00	43.00
44.00	SPECIAL EVENTS	A -701	ADMINISTRATIVE & GENERAL	5.00	44.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet A-8

Date/Time Prepared:
1/30/2012 12:55 pm

Expense Classification on worksheet A
To/From which the Amount is to be Adjusted

	Basis/Code (2)	Amount	Cost Center	Line #	
44.01	A	-850	SENIOR CIRCLE	194.02	44.01
45.00	A	-28	ADMINISTRATIVE & GENERAL	5.00	45.00
45.01	A	-410,442	ANESTHESIOLOGY	53.00	45.01
45.02	A	-54,875	ANESTHESIOLOGY	53.00	45.02
45.03	A	-212,921	ADMINISTRATIVE & GENERAL	5.00	45.03
45.04	A	413,103	DIETARY	10.00	45.04
45.05	A	83,055	PHYSICIANS' PRIVATE OFFICES	192.00	45.05
45.06	A	-3,009	ADMINISTRATIVE & GENERAL	5.00	45.06
50.00		-3,811,947			50.00
TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)					

ADJUSTMENTS TO EXPENSES

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet A-8

Date/Time Prepared:
1/30/2012 12:55 pm

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	0	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	9	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	9	26.00
27.00	Depreciation - movable equipment	9	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	FEES FROM INSERVICE EDUCATION	0	33.00
34.00	FITNESS REVENUE	0	34.00
35.00	RENTAL INCOME - SBC & RB SPEC CLINIC	9	35.00
36.00	OTHER MISC REVENUE	0	36.00
37.00	HOSPITAL BAD DEBT	0	37.00
38.00	TELEPHONE SERVICES	0	38.00
38.01	TELEPHONE SERVICES	0	38.01
38.02	TELEPHONE SERVICES	0	38.02
38.03	TELEPHONE SERVICES	0	38.03
38.04	TELEPHONE DEPRECIATION	9	38.04
39.00	ADVERTISING	0	39.00
39.01	ADVERTISING	0	39.01
40.00	CLUB DUES AND LOBBYING	0	40.00
41.00	PHYSICIAN RECRUITING	0	41.00
42.00	LOBBYING EXPENSE IN ASSOCIATION DUES	0	42.00
43.00	ALCOHOLIC BEVERAGES	0	43.00
44.00	SPECIAL EVENTS	0	44.00
44.01	SPECIAL EVENTS	0	44.01
45.00	LATE FEES AND PENALTIES	0	45.00
45.01	CRNA COSTS	0	45.01
45.02	CRNA BENEFITS	0	45.02
45.03	ILLINOIS PROVIDER TAX	0	45.03
45.04	ADD BACK NH CREDIT FOR DIETARY	0	45.04
45.05	REMOVAL OF LEASE REVENUE	0	45.05
45.06	LEGAL FEES	0	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-1

Date/Time Prepared:
1/30/2012 12:55 pm

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

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

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 141348
 Period: From 07/01/2010 To 06/30/2011
 Worksheet A-8-1
 Date/Time Prepared: 1/30/2012 12:55 pm

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	61,250	0	61,250	9	1.00
2.00	99,972	0	99,972	0	2.00
3.00	9,121	0	9,121	14	3.00
4.00	7,548	0	7,548	14	4.00
4.01	42,316	0	42,316	14	4.01
4.02	377,034	550,866	-173,832	0	4.02
4.03	125,649	548,381	-422,732	0	4.03
4.04	0	1,265,229	-1,265,229	0	4.04
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	2,364,476	-1,641,586		5.00

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

Related Organization(s) and/or Home office		
Name	Percentage of Ownership	Type of Business
4.00	5.00	6.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	COMMUNITY HEALTH SYSTEMS	0.00	HOSPITAL MANAGEMENT COMPA	6.00
7.00	PASI	100.00	COLLECTION AGENCY	7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 - B. Corporation, partnership, or other organization has financial interest in provider.
 - C. Provider has financial interest in corporation, partnership, or other organization.
 - D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
 - E. Individual is director, officer, administrator, or key person of provider and related organization.
 - F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet A-8-2

Date/Time Prepared:
1/30/2012 12:55 pm

	wkst. A Line #		Total Remuneration	Professional Component	
	1.00	2.00			
1.00	5.00	ADMINISTRATIVE & GENERAL	4,043	2,400	1.00
2.00	69.00	ELECTROCARDIOLOGY	12,370	12,370	2.00
3.00	88.00	RURAL HEALTH CLINIC	21,800	0	3.00
4.00	91.00	EMERGENCY	1,139,943	540,903	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	1,178,156	555,673	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
1/30/2012 12:55 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	1,643	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	21,800	0	0	0	0	3.00
4.00	599,040	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	622,483					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet A-8-2

Date/Time Prepared:
1/30/2012 12:55 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet A-8-2

Date/Time Prepared:
1/30/2012 12:55 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	2,400	1.00
2.00	0	12,370	2.00
3.00	0	0	3.00
4.00	0	540,903	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	555,673	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	worksheet A-8-3 Par Date/Time Prepared: 1/30/2012 12:55 pm
		Speech Pathology	Cost

	1.00	
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PART I - GENERAL INFORMATION

1.00	Total number of weeks worked (excluding aides) (see instructions)		64	1.00			
2.00	Line 1 multiplied by 15 hours per week		960	2.00			
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		446	3.00			
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00			
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00			
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00			
7.00	Standard travel expense rate		3.50	7.00			
8.00	Optional travel expense rate per mile		0.00	8.00			
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	851.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.09	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.54	33.54	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

1.00

Part II - SALARY EQUIVALENCY COMPUTATION

14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		57,094	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)		57,094	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)		57,094	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)		67.09	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		64,406	22.00
23.00	Total salary equivalency (see instructions)		64,406	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)		14,959	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)		14,959	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,561	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		16,520	28.00

Optional Travel Allowance and Optional Travel Expense

29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		16,520	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00

Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense

36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00

Optional Travel Allowance and Optional Travel Expense

40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00

Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.

44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/30/2012 12:55 pm
		Speech Pathology	Cost

					1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)				0	46.00
		Therapists	Assistants	Aides	Trainees	Total
		1.00	2.00	3.00	4.00	5.00

PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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)	67.09	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
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Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					64,406	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					16,520	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)					80,926	63.00
64.00	Total cost of outside supplier services (from your records)					48,966	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					14,959	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,561	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					16,520	100.02

LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,561	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					1,561	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		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	443,168	443,168			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	988,894		988,894		2.00
4.00	EMPLOYEE BENEFITS	1,199,450	3,867	9,726	1,213,043	4.00
5.00	ADMINISTRATIVE & GENERAL	2,846,437	72,876	183,289	171,648	5.00
7.00	OPERATION OF PLANT	957,046	112,927	284,021	28,058	7.00
8.00	LAUNDRY & LINEN SERVICE	109,982	806	2,027	0	8.00
9.00	HOUSEKEEPING	182,883	6,654	16,736	21,244	9.00
10.00	DIETARY	1,162,452	20,480	51,510	0	10.00
11.00	CAFETERIA	89,630	10,285	25,867	0	11.00
13.00	NURSING ADMINISTRATION	684,515	8,140	20,474	91,776	13.00
14.00	CENTRAL SERVICES & SUPPLY	79,319	0	0	5,362	14.00
15.00	PHARMACY	347,432	0	0	33,219	15.00
16.00	MEDICAL RECORDS & LIBRARY	344,105	10,806	27,178	27,451	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,537,486	42,406	106,656	174,908	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	531,675	26,425	66,461	59,586	50.00
53.00	ANESTHESIOLOGY	-39,824	773	1,943	55,154	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,283,991	23,305	58,614	94,289	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	989,174	10,366	26,071	53,648	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	193,176	3,246	8,164	25,722	65.00
66.00	PHYSICAL THERAPY	369,563	11,179	28,117	50,344	66.00
67.00	OCCUPATIONAL THERAPY	83,317	1,834	4,612	11,405	67.00
68.00	SPEECH PATHOLOGY	48,966	747	1,878	0	68.00
69.00	ELECTROCARDIOLOGY	96,937	3,649	9,177	4,260	69.00
70.10	CARDIAC REHAB	0	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	170,078	3,102	7,801	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	22,874	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	522,592	5,275	13,268	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	72,767	835	2,101	9,116	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	EMERGENCY	1,517,569	11,083	27,875	225,337	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,835,654	391,066	983,566	1,142,527	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,974	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	18,286	34,905	0	0	192.00
194.00	HOME HEALTH	0	11,593	0	0	194.00
194.01	MARKETING	114,324	2,118	5,328	5,678	194.01
194.02	SENIOR CIRCLE	9,454	1,512	0	1,123	194.02
194.03	RED BUD SPECIALTY CLINIC	0	0	0	0	194.03
194.04	WATERLOO SPECIALTY CLINIC	59,567	0	0	0	194.04
194.05	FREE STANDING NURSING HOME	232,969	0	0	27,416	194.05
194.06	CLINIC CORPORATION	307,073	0	0	36,299	194.06
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)	17,577,327	443,168	988,894	1,213,043	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part I
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	3,274,250					5.00
7.00	OPERATION OF PLANT	333,348	1,715,400				7.00
8.00	LAUNDRY & LINEN SERVICE	27,211	5,853	145,879			8.00
9.00	HOUSEKEEPING	54,877	48,327	13,518	344,239		9.00
10.00	DIETARY	297,745	148,740	8,464	28,655	1,718,046	10.00
11.00	CAFETERIA	30,338	74,692	0	14,389	0	11.00
13.00	NURSING ADMINISTRATION	194,141	59,120	0	11,389	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	20,425	0	0	0	0	14.00
15.00	PHARMACY	91,812	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	98,780	78,478	0	15,119	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	448,974	307,978	61,179	59,333	266,206	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	165,015	191,913	22,035	36,972	0	50.00
53.00	ANESTHESIOLOGY	4,353	5,611	0	1,081	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	352,197	169,253	11,039	32,606	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	260,315	75,283	394	14,503	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	55,550	23,573	0	4,541	0	65.00
66.00	PHYSICAL THERAPY	110,759	81,190	5,954	15,641	0	66.00
67.00	OCCUPATIONAL THERAPY	24,402	13,317	0	2,565	0	67.00
68.00	SPEECH PATHOLOGY	12,444	5,423	0	1,045	0	68.00
69.00	ELECTROCARDIOLOGY	27,502	26,499	1,808	5,105	0	69.00
70.10	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,652	22,526	0	4,340	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	5,517	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	130,521	38,313	0	7,381	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	20,458	6,068	348	1,169	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	429,782	80,492	14,704	15,507	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,240,118	1,462,649	139,443	271,341	266,206	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	476	14,337	0	2,762	8,612	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	127,852	394	48,837	31,203	192.00
194.00	HOME HEALTH	0	84,197	0	16,220	0	194.00
194.01	MARKETING	30,740	15,384	0	2,964	0	194.01
194.02	SENIOR CIRCLE	2,916	10,981	441	2,115	5,002	194.02
194.03	RED BUD SPECIALTY CLINIC	0	0	2,772	0	0	194.03
194.04	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	FREE STANDING NURSING HOME	0	0	0	0	1,407,023	194.05
194.06	CLINIC CORPORATION	0	0	2,829	0	0	194.06
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,274,250	1,715,400	145,879	344,239	1,718,046	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet 8
Part I
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	245,201					11.00
13.00 NURSING ADMINISTRATION	19,012	1,088,567				13.00
14.00 CENTRAL SERVICES & SUPPLY	3,769	0	108,875			14.00
15.00 PHARMACY	5,725	70,741	1,793	550,722		15.00
16.00 MEDICAL RECORDS & LIBRARY	12,977	0	540	0	615,434	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	58,419	372,473	18,058	0	59,744	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	18,559	126,891	10,348	0	72,672	50.00
53.00 ANESTHESIOLOGY	4,795	117,452	859	0	2,231	53.00
54.00 RADIOLOGY-DIAGNOSTIC	30,248	0	5,448	0	178,208	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	19,728	0	34,523	0	144,180	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	8,683	54,776	74	0	10,033	65.00
66.00 PHYSICAL THERAPY	11,856	107,208	664	0	23,232	66.00
67.00 OCCUPATIONAL THERAPY	3,220	24,288	81	0	6,476	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	840	68.00
69.00 ELECTROCARDIOLOGY	811	0	50	0	19,400	69.00
70.10 CARDIAC REHAB	0	0	0	0	0	70.10
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	24,712	0	24,654	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	3,787	0	1,220	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	550,722	22,001	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	2,457	0	514	0	932	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	26,097	214,738	7,389	0	49,611	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
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
118.00 SUBTOTALS (SUM OF LINES 1-117)	226,356	1,088,567	108,840	550,722	615,434	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
194.00 HOME HEALTH	0	0	0	0	0	194.00
194.01 MARKETING	2,147	0	0	0	0	194.01
194.02 SENIOR CIRCLE	453	0	35	0	0	194.02
194.03 RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04 WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05 FREE STANDING NURSING HOME	7,824	0	0	0	0	194.05
194.06 CLINIC CORPORATION	8,421	0	0	0	0	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	245,201	1,088,567	108,875	550,722	615,434	202.00

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
13.00	NURSING ADMINISTRATION				13.00
14.00	CENTRAL SERVICES & SUPPLY				14.00
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	3,513,820	0	3,513,820	30.00
41.00	SUBPROVIDER - IRF	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	1,328,552	0	1,328,552	50.00
53.00	ANESTHESIOLOGY	154,428	0	154,428	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,239,198	0	2,239,198	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	1,628,185	0	1,628,185	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
65.00	RESPIRATORY THERAPY	387,538	0	387,538	65.00
66.00	PHYSICAL THERAPY	815,707	0	815,707	66.00
67.00	OCCUPATIONAL THERAPY	175,517	0	175,517	67.00
68.00	SPEECH PATHOLOGY	71,343	0	71,343	68.00
69.00	ELECTROCARDIOLOGY	195,198	0	195,198	69.00
70.10	CARDIAC REHAB	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	300,865	0	300,865	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	33,398	0	33,398	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,290,073	0	1,290,073	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	116,765	0	116,765	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	EMERGENCY	2,620,184	0	2,620,184	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	101.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,870,771	0	14,870,771	118.00
NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,161	0	28,161	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	261,477	0	261,477	192.00
194.00	HOME HEALTH	112,010	0	112,010	194.00
194.01	MARKETING	178,683	0	178,683	194.01
194.02	SENIOR CIRCLE	34,032	0	34,032	194.02
194.03	RED BUD SPECIALTY CLINIC	2,772	0	2,772	194.03
194.04	WATERLOO SPECIALTY CLINIC	59,567	0	59,567	194.04
194.05	FREE STANDING NURSING HOME	1,675,232	0	1,675,232	194.05
194.06	CLINIC CORPORATION	354,622	0	354,622	194.06
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	17,577,327	0	17,577,327	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part II
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	3,867	9,726	13,593	4.00
5.00	ADMINISTRATIVE & GENERAL	0	72,876	183,289	256,165	5.00
7.00	OPERATION OF PLANT	0	112,927	284,021	396,948	7.00
8.00	LAUNDRY & LINEN SERVICE	0	806	2,027	2,833	8.00
9.00	HOUSEKEEPING	0	6,654	16,736	23,390	9.00
10.00	DIETARY	0	20,480	51,510	71,990	10.00
11.00	CAFETERIA	0	10,285	25,867	36,152	11.00
13.00	NURSING ADMINISTRATION	0	8,140	20,474	28,614	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	10,806	27,178	37,984	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	42,406	106,656	149,062	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	26,425	66,461	92,886	50.00
53.00	ANESTHESIOLOGY	0	773	1,943	2,716	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	23,305	58,614	81,919	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	10,366	26,071	36,437	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	3,246	8,164	11,410	65.00
66.00	PHYSICAL THERAPY	0	11,179	28,117	39,296	66.00
67.00	OCCUPATIONAL THERAPY	0	1,834	4,612	6,446	67.00
68.00	SPEECH PATHOLOGY	0	747	1,878	2,625	68.00
69.00	ELECTROCARDIOLOGY	0	3,649	9,177	12,826	69.00
70.10	CARDIAC REHAB	0	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,102	7,801	10,903	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,275	13,268	18,543	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	835	2,101	2,936	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	EMERGENCY	0	11,083	27,875	38,958	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	391,066	983,566	1,374,632	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,974	0	1,974	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	34,905	0	34,905	192.00
194.00	HOME HEALTH	0	11,593	0	11,593	194.00
194.01	MARKETING	0	2,118	5,328	7,446	194.01
194.02	SENIOR CIRCLE	0	1,512	0	1,512	194.02
194.03	RED BUD SPECIALTY CLINIC	0	0	0	0	194.03
194.04	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05	FREE STANDING NURSING HOME	0	0	0	0	194.05
194.06	CLINIC CORPORATION	0	0	0	0	194.06
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	443,168	988,894	1,432,062	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part II
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	258,088					5.00
7.00	OPERATION OF PLANT	26,276	423,538				7.00
8.00	LAUNDRY & LINEN SERVICE	2,145	1,445	6,423			8.00
9.00	HOUSEKEEPING	4,326	11,932	595	40,481		9.00
10.00	DIETARY	23,469	36,724	373	3,370	135,926	10.00
11.00	CAFETERIA	2,391	18,442	0	1,692	0	11.00
13.00	NURSING ADMINISTRATION	15,303	14,597	0	1,339	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,610	0	0	0	0	14.00
15.00	PHARMACY	7,237	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	7,786	19,376	0	1,778	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	35,389	76,042	2,695	6,977	21,061	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	13,007	47,384	970	4,348	0	50.00
53.00	ANESTHESIOLOGY	343	1,385	0	127	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	27,761	41,789	486	3,834	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	20,519	18,588	17	1,706	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	4,379	5,820	0	534	0	65.00
66.00	PHYSICAL THERAPY	8,730	20,046	262	1,839	0	66.00
67.00	OCCUPATIONAL THERAPY	1,923	3,288	0	302	0	67.00
68.00	SPEECH PATHOLOGY	981	1,339	0	123	0	68.00
69.00	ELECTROCARDIOLOGY	2,168	6,543	80	600	0	69.00
70.10	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,441	5,562	0	510	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	435	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	10,288	9,460	0	868	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	1,613	1,498	15	137	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	33,877	19,874	647	1,824	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	255,397	361,134	6,140	31,908	21,061	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38	3,540	0	325	681	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	31,567	17	5,743	2,469	192.00
194.00	HOME HEALTH	0	20,788	0	1,907	0	194.00
194.01	MARKETING	2,423	3,798	0	349	0	194.01
194.02	SENIOR CIRCLE	230	2,711	19	249	396	194.02
194.03	RED BUD SPECIALTY CLINIC	0	0	122	0	0	194.03
194.04	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	FREE STANDING NURSING HOME	0	0	0	0	111,319	194.05
194.06	CLINIC CORPORATION	0	0	125	0	0	194.06
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	258,088	423,538	6,423	40,481	135,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet B
Part II
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	58,677					11.00
13.00 NURSING ADMINISTRATION	4,550	65,431				13.00
14.00 CENTRAL SERVICES & SUPPLY	902	0	2,572			14.00
15.00 PHARMACY	1,370	4,252	42	13,273		15.00
16.00 MEDICAL RECORDS & LIBRARY	3,105	0	13	0	70,350	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	13,981	22,388	427	0	6,830	30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	4,441	7,627	244	0	8,308	50.00
53.00 ANESTHESIOLOGY	1,147	7,060	20	0	255	53.00
54.00 RADIOLOGY-DIAGNOSTIC	7,238	0	129	0	20,368	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	4,721	0	815	0	16,482	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	2,078	3,292	2	0	1,147	65.00
66.00 PHYSICAL THERAPY	2,837	6,444	16	0	2,656	66.00
67.00 OCCUPATIONAL THERAPY	771	1,460	2	0	740	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	96	68.00
69.00 ELECTROCARDIOLOGY	194	0	1	0	2,218	69.00
70.10 CARDIAC REHAB	0	0	0	0	0	70.10
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	584	0	2,818	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	89	0	139	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	13,273	2,515	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	588	0	12	0	107	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	6,245	12,908	175	0	5,671	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
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
118.00 SUBTOTALS (SUM OF LINES 1-117)	54,168	65,431	2,571	13,273	70,350	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
194.00 HOME HEALTH	0	0	0	0	0	194.00
194.01 MARKETING	514	0	0	0	0	194.01
194.02 SENIOR CIRCLE	108	0	1	0	0	194.02
194.03 RED BUD SPECIALTY CLINIC	0	0	0	0	0	194.03
194.04 WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05 FREE STANDING NURSING HOME	1,872	0	0	0	0	194.05
194.06 CLINIC CORPORATION	2,015	0	0	0	0	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	58,677	65,431	2,572	13,273	70,350	202.00

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
13.00	NURSING ADMINISTRATION				13.00
14.00	CENTRAL SERVICES & SUPPLY				14.00
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	336,812	0	336,812	30.00
41.00	SUBPROVIDER - IRF	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	179,883	0	179,883	50.00
53.00	ANESTHESIOLOGY	13,671	0	13,671	53.00
54.00	RADIOLOGY-DIAGNOSTIC	184,580	0	184,580	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	99,886	0	99,886	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
65.00	RESPIRATORY THERAPY	28,950	0	28,950	65.00
66.00	PHYSICAL THERAPY	82,690	0	82,690	66.00
67.00	OCCUPATIONAL THERAPY	15,060	0	15,060	67.00
68.00	SPEECH PATHOLOGY	5,164	0	5,164	68.00
69.00	ELECTROCARDIOLOGY	24,678	0	24,678	69.00
70.10	CARDIAC REHAB	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,818	0	23,818	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	663	0	663	72.00
73.00	DRUGS CHARGED TO PATIENTS	54,947	0	54,947	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	7,008	0	7,008	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	EMERGENCY	122,705	0	122,705	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	101.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,180,515	0	1,180,515	118.00
NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,558	0	6,558	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	74,701	0	74,701	192.00
194.00	HOME HEALTH	34,288	0	34,288	194.00
194.01	MARKETING	14,594	0	14,594	194.01
194.02	SENIOR CIRCLE	5,239	0	5,239	194.02
194.03	RED BUD SPECIALTY CLINIC	122	0	122	194.03
194.04	WATERLOO SPECIALTY CLINIC	0	0	0	194.04
194.05	FREE STANDING NURSING HOME	113,498	0	113,498	194.05
194.06	CLINIC CORPORATION	2,547	0	2,547	194.06
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,432,062	0	1,432,062	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT	119,878						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		106,357					2.00
4.00 EMPLOYEE BENEFITS	1,046	1,046	8,109,088				4.00
5.00 ADMINISTRATIVE & GENERAL	19,713	19,713	1,147,449	-3,274,250	13,574,969		5.00
7.00 OPERATION OF PLANT	30,547	30,547	187,563	0	1,382,052		7.00
8.00 LAUNDRY & LINEN SERVICE	218	218	0	0	112,815		8.00
9.00 HOUSEKEEPING	1,800	1,800	142,015	0	227,517		9.00
10.00 DIETARY	5,540	5,540	0	0	1,234,442		10.00
11.00 CAFETERIA	2,782	2,782	0	0	125,782		11.00
13.00 NURSING ADMINISTRATION	2,202	2,202	613,515	0	804,905		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	35,842	0	84,681		14.00
15.00 PHARMACY	0	0	222,066	0	380,651		15.00
16.00 MEDICAL RECORDS & LIBRARY	2,923	2,923	183,504	0	409,540		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	11,471	11,471	1,169,240	0	1,861,456		30.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0		41.00
42.00 SUBPROVIDER	0	0	0	0	0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	7,148	7,148	398,327	0	684,147		50.00
53.00 ANESTHESIOLOGY	209	209	368,699	0	18,046		53.00
54.00 RADIOLOGY-DIAGNOSTIC	6,304	6,304	630,313	0	1,460,199		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	2,804	2,804	358,630	0	1,079,259		60.00
60.01 BLOOD LABORATORY	0	0	0	0	0		60.01
65.00 RESPIRATORY THERAPY	878	878	171,950	0	230,308		65.00
66.00 PHYSICAL THERAPY	3,024	3,024	336,542	0	459,203		66.00
67.00 OCCUPATIONAL THERAPY	496	496	76,243	0	101,168		67.00
68.00 SPEECH PATHOLOGY	202	202	0	0	51,591		68.00
69.00 ELECTROCARDIOLOGY	987	987	28,476	0	114,023		69.00
70.10 CARDIAC REHAB	0	0	0	0	0		70.10
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	839	839	0	0	180,981		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	22,874		72.00
73.00 DRUGS CHARGED TO PATIENTS	1,427	1,427	0	0	541,135		73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	226	226	60,942	0	84,819		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0		89.00
91.00 EMERGENCY	2,998	2,998	1,506,382	0	1,781,864		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS							
99.10 CORF	0	0	0	0	0		99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0		101.00
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
118.00 SUBTOTALS (SUM OF LINES 1-117)	105,784	105,784	7,637,698	-3,274,250	13,433,458		118.00
NONREIMBURSABLE COST CENTERS							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	534	0	0	0	1,974		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	9,442	0	0	-53,191	0		192.00
194.00 HOME HEALTH	3,136	0	0	-11,593	0		194.00
194.01 MARKETING	573	573	37,959	0	127,448		194.01
194.02 SENIOR CIRCLE	409	0	7,506	0	12,089		194.02
194.03 RED BUD SPECIALTY CLINIC	0	0	0	0	0		194.03
194.04 WATERLOO SPECIALTY CLINIC	0	0	0	-59,567	0		194.04
194.05 FREE STANDING NURSING HOME	0	0	183,272	-260,385	0		194.05
194.06 CLINIC CORPORATION	0	0	242,653	-343,372	0		194.06
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per wkst. B, Part I)	443,168	988,894	1,213,043		3,274,250		202.00
203.00 Unit cost multiplier (wkst. B, Part I)	3.696825	9.297874	0.149591		0.241198		203.00
204.00 Cost to be allocated (per wkst. B, Part II)			13,593		258,088		204.00
205.00 Unit cost multiplier (wkst. B, Part II)			0.001676		0.019012		205.00

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	63,892					7.00
8.00	LAUNDRY & LINEN SERVICE	218	116,136				8.00
9.00	HOUSEKEEPING	1,800	10,762	66,554			9.00
10.00	DIETARY	5,540	6,738	5,540	122,287		10.00
11.00	CAFETERIA	2,782	0	2,782	0	10,279	11.00
13.00	NURSING ADMINISTRATION	2,202	0	2,202	0	797	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	158	14.00
15.00	PHARMACY	0	0	0	0	240	15.00
16.00	MEDICAL RECORDS & LIBRARY	2,923	0	2,923	0	544	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	11,471	48,706	11,471	18,948	2,449	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7,148	17,542	7,148	0	778	50.00
53.00	ANESTHESIOLOGY	209	0	209	0	201	53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,304	8,788	6,304	0	1,268	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	2,804	314	2,804	0	827	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	878	0	878	0	364	65.00
66.00	PHYSICAL THERAPY	3,024	4,740	3,024	0	497	66.00
67.00	OCCUPATIONAL THERAPY	496	0	496	0	135	67.00
68.00	SPEECH PATHOLOGY	202	0	202	0	0	68.00
69.00	ELECTROCARDIOLOGY	987	1,439	987	0	34	69.00
70.10	CARDIAC REHAB	0	0	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	839	0	839	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,427	0	1,427	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	226	277	226	0	103	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	2,998	11,706	2,998	0	1,094	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	54,478	111,012	52,460	18,948	9,489	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	534	0	534	613	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	4,762	314	9,442	2,221	0	192.00
194.00	HOME HEALTH	3,136	0	3,136	0	0	194.00
194.01	MARKETING	573	0	573	0	90	194.01
194.02	SENIOR CIRCLE	409	351	409	356	19	194.02
194.03	RED BUD SPECIALTY CLINIC	0	2,207	0	0	0	194.03
194.04	WATERLOO SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	FREE STANDING NURSING HOME	0	0	0	100,149	328	194.05
194.06	CLINIC CORPORATION	0	2,252	0	0	353	194.06
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,715,400	145,879	344,239	1,718,046	245,201	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	26.848432	1.256105	5.172326	14.049294	23.854558	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	423,538	6,423	40,481	135,926	58,677	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	6.628968	0.055306	0.608243	1.111533	5.708435	205.00

Cost Center Description		NURSING ADMINISTRATION (NURSING SALARIES) 13.00	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14.00	PHARMACY (COSTED REQUIS.) 15.00	MEDICAL RECORDS & LIBRARY (GROSS REVENUE) 16.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION	3,417,160				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	657,540			14.00
15.00	PHARMACY	222,066	10,826	527,353		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	3,262	0	74,923,463	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,169,240	109,058	0	7,273,428	30.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	398,327	62,495	0	8,847,349	50.00
53.00	ANESTHESIOLOGY	368,699	5,187	0	271,599	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	32,905	0	21,694,226	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	208,492	0	17,552,982	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	171,950	447	0	1,221,426	65.00
66.00	PHYSICAL THERAPY	336,542	4,013	0	2,828,284	66.00
67.00	OCCUPATIONAL THERAPY	76,243	489	0	788,444	67.00
68.00	SPEECH PATHOLOGY	0	0	0	102,212	68.00
69.00	ELECTROCARDIOLOGY	0	302	0	2,361,773	69.00
70.10	CARDIAC REHAB	0	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	149,247	0	3,001,412	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	22,874	0	148,554	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	527,353	2,678,427	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	3,107	0	113,509	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	EMERGENCY	674,093	44,625	0	6,039,838	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,417,160	657,329	527,353	74,923,463	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	HOME HEALTH	0	0	0	0	194.00
194.01	MARKETING	0	0	0	0	194.01
194.02	SENIOR CIRCLE	0	211	0	0	194.02
194.03	RED BUD SPECIALTY CLINIC	0	0	0	0	194.03
194.04	WATERLOO SPECIALTY CLINIC	0	0	0	0	194.04
194.05	FREE STANDING NURSING HOME	0	0	0	0	194.05
194.06	CLINIC CORPORATION	0	0	0	0	194.06
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,088,567	108,875	550,722	615,434	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.318559	0.165579	1.044314	0.008214	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	65,431	2,572	13,273	70,350	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.019148	0.003912	0.025169	0.000939	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Total Costs			
			Total Costs	Costs		Total Costs				
				RCE Disallowance	Cost					
	1.00	2.00	3.00	4.00	5.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	ADULTS & PEDIATRICS		3,513,820				3,513,820	0	0	30.00
41.00	SUBPROVIDER - IRF		0				0	0	0	41.00
42.00	SUBPROVIDER		0				0	0	0	42.00
ANCILLARY SERVICE COST CENTERS										
50.00	OPERATING ROOM		1,328,552				1,328,552	0	0	50.00
53.00	ANESTHESIOLOGY		154,428				154,428	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		2,239,198				2,239,198	0	0	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		1,628,185				1,628,185	0	0	60.00
60.01	BLOOD LABORATORY		0				0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	387,538				387,538	0	0	65.00
66.00	PHYSICAL THERAPY	0	815,707				815,707	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	175,517				175,517	0	0	67.00
68.00	SPEECH PATHOLOGY	0	71,343				71,343	0	0	68.00
69.00	ELECTROCARDIOLOGY		195,198				195,198	0	0	69.00
70.10	CARDIAC REHAB		0				0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		300,865				300,865	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		33,398				33,398	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,290,073				1,290,073	0	0	73.00
OUTPATIENT SERVICE COST CENTERS										
88.00	RURAL HEALTH CLINIC		116,765				116,765	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0				0	0	0	89.00
91.00	EMERGENCY		2,620,184				2,620,184	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		115,624				115,624	0	0	92.00
OTHER REIMBURSABLE COST CENTERS										
99.10	CORF		0				0	0	0	99.10
101.00	HOME HEALTH AGENCY		0				0	0	0	101.00
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
200.00	Subtotal (see instructions)		14,986,395	0			14,986,395	0	0	200.00
201.00	Less Observation Beds		115,624				115,624	0	0	201.00
202.00	Total (see instructions)		14,870,771	0			14,870,771	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	Charges			Hospital Cost or Other Ratio	Cost TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	7,261,870		7,261,870			30.00
41.00 SUBPROVIDER - IRF	0		0			41.00
42.00 SUBPROVIDER	0		0			42.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,631,986	7,215,363	8,847,349	0.150164	0.000000	50.00
53.00 ANESTHESIOLOGY	63,527	208,072	271,599	0.568588	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,888,528	18,805,698	21,694,226	0.103216	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	4,171,717	13,381,265	17,552,982	0.092758	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 RESPIRATORY THERAPY	971,972	249,454	1,221,426	0.317283	0.000000	65.00
66.00 PHYSICAL THERAPY	1,439,593	1,388,691	2,828,284	0.288411	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	710,672	77,772	788,444	0.222612	0.000000	67.00
68.00 SPEECH PATHOLOGY	76,668	25,544	102,212	0.697990	0.000000	68.00
69.00 ELECTROCARDIOLOGY	191,733	2,170,040	2,361,773	0.082649	0.000000	69.00
70.10 CARDIAC REHAB	0	0	0	0.000000	0.000000	70.10
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,515,154	1,486,258	3,001,412	0.100241	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	35,394	113,160	148,554	0.224821	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,442,489	1,235,938	2,678,427	0.481653	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	113,509	113,509			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00 EMERGENCY	269,782	5,781,613	6,051,395	0.432988	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	33,746	253,250	286,996	0.402877	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0			99.10
101.00 HOME HEALTH AGENCY	0	0	0			101.00
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
200.00 Subtotal (see instructions)	22,704,831	52,505,627	75,210,458			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	22,704,831	52,505,627	75,210,458			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
1/30/2012 12:55 pm

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
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
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
70.10	CARDIAC REHAB	0.000000			70.10
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
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF				99.10
101.00	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION				109.00
110.00	INTESTINAL ACQUISITION				110.00
111.00	ISLET ACQUISITION				111.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet D
Part II
Date/Time Prepared:
1/30/2012 12:55 pm

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	179,883	8,847,349	0.020332	665,787	13,537	50.00
53.00	ANESTHESIOLOGY	13,671	271,599	0.050335	25,413	1,279	53.00
54.00	RADIOLOGY-DIAGNOSTIC	184,580	21,694,226	0.008508	1,501,373	12,774	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	99,886	17,552,982	0.005691	2,222,843	12,650	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	28,950	1,221,426	0.023702	482,714	11,441	65.00
66.00	PHYSICAL THERAPY	82,690	2,828,284	0.029237	192,879	5,639	66.00
67.00	OCCUPATIONAL THERAPY	15,060	788,444	0.019101	32,026	612	67.00
68.00	SPEECH PATHOLOGY	5,164	102,212	0.050522	23,809	1,203	68.00
69.00	ELECTROCARDIOLOGY	24,678	2,361,773	0.010449	112,302	1,173	69.00
70.10	CARDIAC REHAB	0	0	0.000000	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,818	3,001,412	0.007936	716,327	5,685	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	663	148,554	0.004463	1,872	8	72.00
73.00	DRUGS CHARGED TO PATIENTS	54,947	2,678,427	0.020515	658,262	13,504	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	7,008	113,509	0.061740	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	122,705	6,051,395	0.020277	2,383	48	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	286,996	0.000000	0	0	92.00
200.00	Total (lines 50-199)	843,703	67,948,588		6,637,990	79,553	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	Title XVIII				Hospital All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)
	Non Physician Anesthetist Cost	Nursing School	Allied Health			
	1.00	2.00	3.00	4.00		
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
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
70.10	CARDIAC REHAB	0	0	0	0	0 70.10
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
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
91.00	EMERGENCY	0	0	0	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
200.00	Total (lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description		Title XVIII			Hospital		Cost
		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	8,847,349	0.000000	0.000000	665,787	50.00
53.00	ANESTHESIOLOGY	0	271,599	0.000000	0.000000	25,413	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	21,694,226	0.000000	0.000000	1,501,373	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	17,552,982	0.000000	0.000000	2,222,843	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0	1,221,426	0.000000	0.000000	482,714	65.00
66.00	PHYSICAL THERAPY	0	2,828,284	0.000000	0.000000	192,879	66.00
67.00	OCCUPATIONAL THERAPY	0	788,444	0.000000	0.000000	32,026	67.00
68.00	SPEECH PATHOLOGY	0	102,212	0.000000	0.000000	23,809	68.00
69.00	ELECTROCARDIOLOGY	0	2,361,773	0.000000	0.000000	112,302	69.00
70.10	CARDIAC REHAB	0	0	0.000000	0.000000	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,001,412	0.000000	0.000000	716,327	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	148,554	0.000000	0.000000	1,872	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,678,427	0.000000	0.000000	658,262	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	113,509	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	6,051,395	0.000000	0.000000	2,383	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	286,996	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	0	67,948,588			6,637,990	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet D
Part IV
Date/Time Prepared:
1/30/2012 12:55 pm

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	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
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
70.10 CARDIAC REHAB	0	0	0	0	0	70.10
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
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
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/30/2012 12:55 pm

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
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
70.10	CARDIAC REHAB	0	0			70.10
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
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part V
Date/Time Prepared:
1/30/2012 12:55 pm

Title XVIII

Hospital

Cost

Cost Center Description	Cost to Charge Ratio From worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges		Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	Cost
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.150164	0	2,130,297	0	50.00
53.00	ANESTHESIOLOGY	0.568588	0	52,785	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.103216	0	6,805,327	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	0.092758	0	6,220,122	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0.317283	0	122,698	0	65.00
66.00	PHYSICAL THERAPY	0.288411	0	456,812	0	66.00
67.00	OCCUPATIONAL THERAPY	0.222612	0	42,731	0	67.00
68.00	SPEECH PATHOLOGY	0.697990	0	4,603	0	68.00
69.00	ELECTROCARDIOLOGY	0.082649	0	1,574,803	0	69.00
70.10	CARDIAC REHAB	0.000000	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100241	0	255,330	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.224821	0	45,803	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.481653	0	521,981	117	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00	EMERGENCY	0.432988	0	2,029,441	117	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.402877	0	94,197	0	92.00
200.00	Subtotal (see instructions)		0	20,356,930	234	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	20,356,930	234	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/30/2012 12:55 pm
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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	319,894	0	50.00
53.00	ANESTHESIOLOGY	0	30,013	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	702,419	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	576,966	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	38,930	0	65.00
66.00	PHYSICAL THERAPY	0	131,750	0	66.00
67.00	OCCUPATIONAL THERAPY	0	9,512	0	67.00
68.00	SPEECH PATHOLOGY	0	3,213	0	68.00
69.00	ELECTROCARDIOLOGY	0	130,156	0	69.00
70.10	CARDIAC REHAB	0	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,595	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	10,297	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	251,414	56	73.00
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
91.00	EMERGENCY	0	878,724	51	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	37,950	0	92.00
200.00	Subtotal (see instructions)	0	3,146,833	107	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	3,146,833	107	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141348 Component CCN: 14Z348	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/30/2012 12:55 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges		Cost
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.150164	0	0	0	50.00
53.00 ANESTHESIOLOGY	0.568588	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.103216	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	0.092758	0	0	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0.317283	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.288411	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0.222612	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0.697990	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.082649	0	0	0	69.00
70.10 CARDIAC REHAB	0.000000	0	0	0	70.10
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100241	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.224821	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.481653	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00 EMERGENCY	0.432988	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.402877	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141348 Component CCN:14Z348	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/30/2012 12:55 pm
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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
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
70.10 CARDIAC REHAB	0	0	0		70.10
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
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
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/30/2012 12:55 pm
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)			6,124 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,009 2.00
3.00	Private room days (excluding swing-bed and observation bed days)			114 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,895 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,377 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			1,377 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			180 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)			181 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			2,144 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)			1,377 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)			1,377 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			119.88 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			119.88 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,513,820 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)			21,578 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)			21,698 25.00
26.00	Total swing-bed cost (see instructions)			1,701,762 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,812,058 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			4,653,770 28.00
29.00	Private room charges (excluding swing-bed charges)			180,820 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			4,472,950 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.389374 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			1,586.14 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,545.06 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			41.08 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			16.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			1,824 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,810,234 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)			601.61 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,289,852 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,289,852 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	worksheet D-1	
		Title XVIII		Hospital	
Date/Time Prepared: 1/30/2012 12:55 pm		Cost			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title v & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)				1,107,705 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,397,557 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)				829,243 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				829,243 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				1,658,486 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)				192 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				602.21 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				115,624 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	Cost	Title XVIII		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Cost		
	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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3	
		Title XVIII	Hospital	Date/Time Prepared: 1/30/2012 12:55 pm	
Cost Center Description	Ratio of Cost To Charges	Cost			
		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		3,557,478	30.00	
41.00	SUBPROVIDER - IRF		0	41.00	
42.00	SUBPROVIDER		0	42.00	
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.150164	665,787	99,977	50.00
53.00	ANESTHESIOLOGY	0.568588	25,413	14,450	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.103216	1,501,373	154,966	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	0.092758	2,222,843	206,186	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.317283	482,714	153,157	65.00
66.00	PHYSICAL THERAPY	0.288411	192,879	55,628	66.00
67.00	OCCUPATIONAL THERAPY	0.222612	32,026	7,129	67.00
68.00	SPEECH PATHOLOGY	0.697990	23,809	16,618	68.00
69.00	ELECTROCARDIOLOGY	0.082649	112,302	9,282	69.00
70.10	CARDIAC REHAB	0.000000	0	0	70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100241	716,327	71,805	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.224821	1,872	421	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.481653	658,262	317,054	73.00
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
91.00	EMERGENCY	0.432988	2,383	1,032	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.402877	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		6,637,990	1,107,705	200.00
201.00	Less BPB Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		6,637,990		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141348 Component CCN: 142348	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/30/2012 12:55 pm
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		2,312,572	30.00
41.00	SUBPROVIDER - IRF		0	41.00
42.00	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.150164	63,875	9,592 50.00
53.00	ANESTHESIOLOGY	0.568588	0	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.103216	323,934	33,435 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	0.092758	865,555	80,287 60.00
60.01	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	RESPIRATORY THERAPY	0.317283	366,567	116,305 65.00
66.00	PHYSICAL THERAPY	0.288411	1,104,301	318,493 66.00
67.00	OCCUPATIONAL THERAPY	0.222612	601,011	133,792 67.00
68.00	SPEECH PATHOLOGY	0.697990	43,143	30,113 68.00
69.00	ELECTROCARDIOLOGY	0.082649	55,326	4,573 69.00
70.10	CARDIAC REHAB	0.000000	0	0 70.10
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.100241	342,740	34,357 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.224821	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0.481653	458,193	220,690 73.00
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
91.00	EMERGENCY	0.432988	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.402877	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,224,645	981,637 200.00
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)		4,224,645	981,637 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/30/2012 12:55 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,146,940 1.00
2.00	Medical and other services reimbursed under OPPI (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)		3,146,940	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 charge basis 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)		3,178,409	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)		37,499	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		2,841,505	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)		299,405	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)		299,405	30.00
31.00	Primary payer payments		190	31.00
32.00	Subtotal (line 30 minus line 31)		299,215	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)		393,332	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		393,332	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		337,396	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		692,547	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)		692,547	40.00
41.00	Interim payments		1,193,797	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)		-501,250	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		40,167	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: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/30/2012 12:55 pm
	Title XVIII	Hospital	Cost
			Overrides 1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/30/2012 12:55 pm		
		Title XVIII	Hospital	Cost		
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,779,650		1,193,797	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	02/01/2011	80,700		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)		80,700		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,860,350		1,193,797	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		145,797		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		501,250	6.02
7.00	Total Medicare program liability (see instructions)		2,006,147		692,547	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	worksheet E-1 Part I Date/Time Prepared: 1/30/2012 12:55 pm	
		Title XVIII	Swing Beds - SNF	Cost	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		2,329,078		0
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
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/01/2011	72,300		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		72,300		0
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)		2,401,378		0
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
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		185,292		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		2,586,670		0
				Contractor Number	Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2
		Component CCN: 142348		Date/Time Prepared: 1/30/2012 12:55 pm
		Title XVIII	Swing Beds - SNF	Cost
			Part A 1.00	Part B 2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,675,071	0
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)		991,453	0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		2,754	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
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)		2,666,524	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		2,666,524	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		2,666,524	0
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		79,973	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		2,586,551	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
17.00	Reimbursable bad debts (see instructions)		119	0
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		2,586,670	0
20.00	Interim payments		2,401,378	0
21.00	Tentative settlement (for contractor use only)		0	0
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		185,292	0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		33,842	0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/30/2012 12:55 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services			2,397,557 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,397,557 4.00
5.00	Primary payer payments			2,527 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			2,419,006 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,419,006 19.00
20.00	Deductibles (exclude professional component)			450,672 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,968,334 22.00
23.00	Coinsurance			1,925 23.00
24.00	Subtotal (line 22 minus line 23)			1,966,409 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			39,738 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			39,738 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			38,093 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			2,006,147 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,006,147 30.00
31.00	Interim payments			1,860,350 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)			145,797 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS pub. 15-2, section 115.2			29,686 34.00

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

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet G

Date/Time Prepared:
1/30/2012 12:55 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	157,033	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	2,450,938	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-210,920	0	0	0	6.00
7.00	Inventory	426,485	0	0	0	7.00
8.00	Prepaid expenses	185,826	0	0	0	8.00
9.00	Other current assets	-953	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,008,409	0	0	0	11.00
FIXED ASSETS						
12.00	Land	39,727	0	0	0	12.00
13.00	Land improvements	98,110	0	0	0	13.00
14.00	Accumulated depreciation	-67,513	0	0	0	14.00
15.00	Buildings	1,784,726	0	0	0	15.00
16.00	Accumulated depreciation	-750,676	0	0	0	16.00
17.00	Leasehold improvements	1,599,855	0	0	0	17.00
18.00	Accumulated depreciation	-366,505	0	0	0	18.00
19.00	Fixed equipment	829,472	0	0	0	19.00
20.00	Accumulated depreciation	-197,686	0	0	0	20.00
21.00	Automobiles and trucks	2,501	0	0	0	21.00
22.00	Accumulated depreciation	-2,501	0	0	0	22.00
23.00	Major movable equipment	3,744,735	0	0	0	23.00
24.00	Accumulated depreciation	-2,235,222	0	0	0	24.00
25.00	Minor equipment depreciable	1,465,898	0	0	0	25.00
26.00	Accumulated depreciation	-995,630	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,949,291	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	776,126	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	776,126	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,733,826	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,188,939	0	0	0	37.00
38.00	Salaries, wages, and fees payable	773,025	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	9,968,077	0	0	0	43.00
44.00	Other current liabilities	97,256	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,027,297	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,027,297	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-3,293,471	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)	-3,293,471	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,733,826	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-1

Date/Time Prepared:
1/30/2012 12:55 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
	1.00		-4,188,579		
2.00		895,108			2.00
3.00		-3,293,471		0	3.00
4.00	0		0		4.00
5.00	0		0		5.00
6.00	0		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00		0		0	10.00
11.00		-3,293,471		0	11.00
12.00	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		0		0	18.00
19.00		-3,293,471		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

worksheet G-1

Date/Time Prepared:
1/30/2012 12:55 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141348

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-2 Parts

Date/Time Prepared:
1/30/2012 12:55 pm

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital	7,261,870		7,261,870	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	2,305,845		2,305,845	5.00
6.00 Swing bed - NF	302,255		302,255	6.00
7.00 SKILLED NURSING FACILITY				7.00
8.00 NURSING FACILITY				8.00
9.00 OTHER LONG TERM CARE				9.00
10.00 Total general inpatient care services (sum of lines 1-9)	9,869,970		9,869,970	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)	9,869,970		9,869,970	17.00
18.00 Ancillary services	12,834,861	0	12,834,861	18.00
19.00 Outpatient services	0	52,871,817	52,871,817	19.00
20.00 RURAL HEALTH CLINIC	0	0	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00 HOME HEALTH AGENCY		0	0	22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC				24.00
24.10 CORF	0	0	0	24.10
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE				26.00
27.00 PROFESSIONAL FEES	791,851	1,010,158	1,802,009	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	23,496,682	53,881,975	77,378,657	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per wkst. A, column 3, line 200)		21,389,274		29.00
30.00 ADD (SPECIFY)	0			30.00
31.00	0			31.00
32.00	0			32.00
33.00	0			33.00
34.00	0			34.00
35.00	0			35.00
36.00 Total additions (sum of lines 30-35)		0		36.00
37.00 DEDUCT (SPECIFY)	0			37.00
38.00	0			38.00
39.00	0			39.00
40.00	0			40.00
41.00	0			41.00
42.00 Total deductions (sum of lines 37-41)		0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		21,389,274		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/30/2012 12:55 pm
				1.00
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)		77,378,657	1.00
2.00	Less contractual allowances and discounts on patients' accounts		55,341,136	2.00
3.00	Net patient revenues (line 1 minus line 2)		22,037,521	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)		21,389,274	4.00
5.00	Net income from service to patients (line 3 minus line 4)		648,247	5.00
	OTHER INCOME			
6.00	Contributions, donations, bequests, etc		60	6.00
7.00	Income from investments		0	7.00
8.00	Revenues from telephone and telegraph service		0	8.00
9.00	Revenue from television and radio service		0	9.00
10.00	Purchase discounts		0	10.00
11.00	Rebates and refunds of expenses		0	11.00
12.00	Parking lot receipts		0	12.00
13.00	Revenue from laundry and linen service		0	13.00
14.00	Revenue from meals sold to employees and guests		109,169	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		4,761	17.00
18.00	Revenue from sale of medical records and abstracts		20	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		50	21.00
22.00	Rental of hospital space		51,021	22.00
23.00	Governmental appropriations		80,308	23.00
24.00	SILVER RECOVERY / SALE OF SCRAP		1,370	24.00
24.01	INSERVICE EDUCATION		160	24.01
24.02	FITNESS REVENUE		990	24.02
24.03	SENIOR CIRCLE		490	24.03
24.04	MISCELLANEOUS		1,624	24.04
24.05	LOSS ON SALE OF ASSETS		-3,162	24.05
25.00	Total other income (sum of lines 6-24)		246,861	25.00
26.00	Total (line 5 plus line 25)		895,108	26.00
27.00			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)		0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		895,108	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 1/30/2012 12:55 pm
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		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	79,540	0	79,540	0	79,540	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	58,554	0	58,554	0	58,554	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	73,543	0	73,543	0	73,543	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	16,473	0	16,473	0	16,473	9.00
10.00	Subtotal (sum of lines 1-9)	228,110	0	228,110	0	228,110	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	3,302	3,302	0	3,302	15.00
16.00	Transportation (Health Care Staff)	0	1,164	1,164	0	1,164	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	3,800	3,800	0	3,800	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	8,266	8,266	0	8,266	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	228,110	8,266	236,376	0	236,376	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	9,383	9,383	0	9,383	29.00
30.00	Administrative Costs	23,516	36,296	59,812	0	59,812	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	23,516	45,679	69,195	0	69,195	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	251,626	53,945	305,571	0	305,571	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1
	Component CCN: 148514		Date/Time Prepared: 1/30/2012 12:55 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-57,740	21,800	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-45,236	13,318	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	-56,815	16,728	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	-12,726	3,747	9.00
10.00	Subtotal (sum of lines 1-9)	-172,517	55,593	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	-1,750	1,552	15.00
16.00	Transportation (Health Care Staff)	-1,164	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	-2,666	1,134	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)	-5,580	2,686	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-178,097	58,279	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	-9,026	357	29.00
30.00	Administrative Costs	-45,681	14,131	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-54,707	14,488	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-232,804	72,767	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141348	Period: From 07/01/2010 To 06/30/2011	Worksheet M-2	
		Component CCN: 148514		Date/Time Prepared: 1/30/2012 12:55 pm	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00

VISITS AND PRODUCTIVITY

Positions						
1.00	Physician	1.00	379	414	414	1.00
2.00	Physician Assistant	0.00	0	207	0	2.00
3.00	Nurse Practitioner	1.58	263	207	327	3.00
4.00	Subtotal (sum of lines 1-3)	2.58	642		741	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)	2.58	642		741	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)	58,279	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)	58,279	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)	14,488	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	43,998	15.00
16.00	Total overhead (sum of lines 14 and 15)	58,486	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtract line 17 from line 16	58,486	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	58,486	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	116,765	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141348	Period: From 07/01/2010	Worksheet M-3
	Component CCN:148514	To 06/30/2011	Date/Time Prepared: 1/30/2012 12:55 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		1.00	
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DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1.00	Total Allowable Cost of RHC/FQHC Services (from worksheet M-2, line 20)	116,765	1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)	128	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	116,637	3.00
4.00	Total visits (from worksheet M-2, column 5, line 8)	741	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)	741	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	157.40	7.00

Calculation of Limit (1)

	Prior to January 1	On or After January 1	
8.00	0.00	78.07	8.00
9.00	157.40	157.40	9.00

CALCULATION OF SETTLEMENT

10.00	Program covered visits excluding mental health services (from contractor records)	0	483	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	76,024	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	76,024	16.00
16.01	Total program charges (see instructions)(from contractor's records)		41,763	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 line 16.03) times 80%)		59,835	16.04
16.05	Total program cost (see instructions)	0	59,835	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,230	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,090	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		59,835	20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		128	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		59,963	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)		59,963	26.00
27.00	Interim payments		25,066	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)		34,897	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		781	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141348 Component CCN: 148514	Period: From 07/01/2010 To 06/30/2011	worksheet M-4 Date/Time Prepared: 1/30/2012 12:55 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal		Influenza
		1.00	2.00	
1.00	Health care staff cost (from worksheet M-1, column 7, line 10)	55,593	55,593	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000097	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	5	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	59	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	64	0	5.00
6.00	Total direct cost of the facility (from worksheet M-1, column 7, line 22)	58,279	58,279	6.00
7.00	Total overhead (from worksheet M-2, line 16)	58,486	58,486	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001098	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	64	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	128	0	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	128.00	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	128	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to worksheet M-3, line 2)		128	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)		128	16.00

