

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: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 12/16/2011 9:18 am
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PART I - COST REPORT STATUS	
Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.
Date: 12/16/2011 Time: 9:18 am	
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended
6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	
10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SARAH BUSH LINCOLN HEALTH CENTER 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.

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

 Title

 Date

Cost Center Description	Title XVIII		HIT	Title XIX	
	Title V	Part A			
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	373,453	-655,458	0	0
2.00 Subprovider - IPF	0	61,908	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	0	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
7.00 Skilled Nursing Facility	0	0	0	0	0
8.00 Nursing Facility	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	1,136	0	0
10.01 RURAL HEALTH CLINIC II II	0	0	1,822	0	0
10.02 RURAL HEALTH CLINIC III III	0	0	1,415	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
12.00 CMHC I	0	0	0	0	0
200.00 Total	0	435,361	-651,085	0	0

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 140189		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 12/13/2011 3:00 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1000 HEALTH CENTER DRIVE			PO Box: 372							1.00	
2.00	City: MATTOON			State: IL		Zip Code: 61920-		County: COLES			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
								V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		SARAH BUSH LINCOLN HEALTH CENTER		140189	99914	1	05/01/1977	N	P	O	3.00
4.00	Subprovider - IPF		SARAH BUSH LINCOLN HEALTH CENTER		14S189	99914	4	01/01/1990	N	P	O	4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF								N	N	N	7.00
8.00	Swing Beds - NF								N	N	N	8.00
9.00	Hospital-Based SNF								N	N	N	9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA		LINCOLN LAND HOME CARE OF SBLHS		147594	99914		06/18/1996	N	P	N	12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice		LINCOLN LAND HOSPICE OF SBLHS		141599	99914		08/10/1999				14.00
15.00	Hospital-Based Health Clinic - RHC		CASEY RHC		143978	99914		06/15/1992	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1		SULLIVAN RHC		143998	99914		01/13/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC 2		NEOGA RHC		143435	99914		05/31/1997	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) 1											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2010	06/30/2011		20.00		
21.00	Type of Control (see instructions)						2		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? 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.						Y	N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1	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	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.			3,159	0	0	0	0	0		24.00	
25.00	If this provider is an IRF then enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid eligible days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0		25.00	
							1.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.								2		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.								2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								1		35.00	
							Beginning:	Ending:				
							1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						07/01/2010	06/30/2011		36.00		

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		Beginning:	Ending:			
		1.00	2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	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.					Y			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)					N	N	0	71.00
Inpatient Rehabilitation Facility PPS									
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)							0	76.00
						1.00			
Long Term Care Hospital PPS									
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.							N	80.00

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				1.00		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.		N		86.00	
			V	XIX		
			1.00	2.00		
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		Y	N	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)?		N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	N
					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.		33,000,000	37,000,000	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	

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			1.00			2.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			N				140.00
			1.00	2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:		Contractor's Name:		Contractor's Number:			141.00
142.00	Street:		PO Box:					142.00
143.00	City:		State:		Zip Code:			143.00
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					N		145.00
							1.00	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		161.00
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00
			Name		County		State	
			0		1.00		2.00	
			Zip Code		CBSA		FTE/Campus	
			3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/13/2011 3:00 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
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Type	Date
			1.00	2.00	3.00
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	Legal Oper.	
			1.00	2.00	
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.			Y	15.00
			Part A		
			Description	Y/N	Date
			0	1.00	2.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/31/2011		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: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/13/2011 3:00 pm
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		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	N	2.00	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140189

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

Worksheet S-2
Part II
Date/Time Prepared:
12/13/2011 3:00 pm

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/31/2011	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.			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:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140189

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

Worksheet S-3
Part I
Date/Time Prepared:
12/13/2011 3:00 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	91	33,215	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		91	33,215	0.00		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT	32.00	8	2,920	0.00		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	43.00					13.00
14.00 Total (see instructions)		99	36,135	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,300			16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0			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	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.01 RURAL HEALTH CLINIC II	88.01					26.01
26.02 RURAL HEALTH CLINIC III	88.02					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		119				27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF	40.00					28.01
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: 140189

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

Worksheet S-3
Part I
Date/Time Prepared:
12/13/2011 3:00 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	11,484	2,917	19,144		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	11,484	2,917	19,144		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT	0	1,063	242	1,849		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	0		718	1,170		13.00
14.00 Total (see instructions)	0	12,547	3,877	22,163		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	1,252	1,116	3,672		16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0		19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	20,063	0	28,747		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	948	0	4,563		26.00
26.01 RURAL HEALTH CLINIC II	0	546	0	2,861		26.01
26.02 RURAL HEALTH CLINIC III	0	945	0	5,692		26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	2,957		28.00
28.01 SUBPROVIDER - IPF	0	0	0	0		28.01
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part I Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	2,878	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	1,260.46	0.00	0	2,878	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	21.80	0.00	0	255	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00	0.00	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	47.86	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	23.32	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	6.66	0.00			26.00
26.01 RURAL HEALTH CLINIC II	0.00	5.38	0.00			26.01
26.02 RURAL HEALTH CLINIC III	0.00	6.09	0.00			26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	1,371.57	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
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: 140189

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

Worksheet S-3
Part I
Date/Time Prepared:
12/13/2011 3:00 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)	1,165	5,963		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)	1,165	5,963		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	319	918		16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.01 RURAL HEALTH CLINIC II				26.01
26.02 RURAL HEALTH CLINIC III				26.02
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
28.01 SUBPROVIDER - IPF				28.01
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 WAGE INDEX INFORMATION		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part II Date/Time Prepared: 12/13/2011 3:00 pm
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		Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	
		1.00	2.00	2.50	3.00	4.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	85,875,418	0	0	85,875,418	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0	2.00
3.00	Non-physician anesthetist Part B		1,580,354	0	0	1,580,354	3.00
4.00	Physician-Part A		554,630	0	0	554,630	4.00
5.00	Physician-Part B		8,232,151	0	0	8,232,151	5.00
6.00	Non-physician-Part B		518,583	0	0	518,583	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0	7.00
8.00	Home office personnel		0	0	0	0	8.00
9.00	SNF	44.00	0	0	0	0	9.00
10.00	Excluded area salaries (see instructions)		28,473,505	0	0	28,473,505	10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		52,360	0	0	52,360	11.00
12.00	Management and administrative services		0	0	0	0	12.00
13.00	Contract labor: physician-Part A		0	0	0	0	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0	14.00
15.00	Home office: physician Part A		0	0	0	0	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0	16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		22,390,281	0	0	22,390,281	17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		0	0	0	0	18.00
19.00	Excluded areas		4,801,372	0	0	4,801,372	19.00
20.00	Non-physician anesthetist Part A		0	0	0	0	20.00
21.00	Non-physician anesthetist Part B		381,189	0	0	381,189	21.00
22.00	Physician Part A		85,173	0	0	85,173	22.00
23.00	Physician Part B		1,243,750	0	0	1,243,750	23.00
24.00	Wage-related costs (RHC/FOHC)		23,722	0	0	23,722	24.00
25.00	Interns & residents (in an approved program)		0	0	0	0	25.00
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	523,936	0	0	523,936	26.00
27.00	Administrative & General	5.00	9,555,087	0	0	9,555,087	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0	29.00
30.00	Operation of Plant	7.00	935,738	0	0	935,738	30.00
31.00	Laundry & Linen Service	8.00	27,290	0	0	27,290	31.00
32.00	Housekeeping	9.00	1,052,164	0	0	1,052,164	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0	33.00
34.00	Dietary	10.00	1,209,398	0	-675,933	533,465	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0	35.00
36.00	Cafeteria	11.00	0	0	675,933	675,933	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0	37.00
38.00	Nursing Administration	13.00	1,249,872	0	0	1,249,872	38.00
39.00	Central Services and Supply	14.00	376,126	0	0	376,126	39.00
40.00	Pharmacy	15.00	1,091,034	0	0	1,091,034	40.00
41.00	Medical Records & Medical Records Library	16.00	1,374,134	0	0	1,374,134	41.00
42.00	Social Service	17.00	0	0	0	0	42.00
43.00	Other General Service	18.00	0	0	0	0	43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part II Date/Time Prepared: 12/13/2011 3:00 pm
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		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
PART II - WAGE DATA				
SALARIES				
1.00	Total salaries (see instructions)	2,853,089.00	30.10	1.00
2.00	Non-physician anesthetist Part A	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B	18,877.00	83.72	3.00
4.00	Physician-Part A	2,791.00	198.72	4.00
5.00	Physician-Part B	44,111.00	186.62	5.00
6.00	Non-physician-Part B	9,457.00	54.84	6.00
7.00	Interns & residents (in an approved program)	0.00	0.00	7.00
8.00	Home office personnel	0.00	0.00	8.00
9.00	SNF	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)	736,519.00	38.66	10.00
OTHER WAGES & RELATED COSTS				
11.00	Contract labor (see instructions)	436.00	120.09	11.00
12.00	Management and administrative services	0.00	0.00	12.00
13.00	Contract labor: physician-Part A	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs	0.00	0.00	14.00
15.00	Home office: physician Part A	0.00	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	0.00	16.00
WAGE-RELATED COSTS				
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FOHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
OVERHEAD COSTS - DIRECT SALARIES				
26.00	Employee Benefits	17,738.00	29.54	26.00
27.00	Administrative & General	351,852.00	27.16	27.00
28.00	Administrative & General under contract (see inst.)	0.00	0.00	28.00
29.00	Maintenance & Repairs	0.00	0.00	29.00
30.00	Operation of Plant	44,936.00	20.82	30.00
31.00	Laundry & Linen Service	2,161.00	12.63	31.00
32.00	Housekeeping	85,499.00	12.31	32.00
33.00	Housekeeping under contract (see instructions)	0.00	0.00	33.00
34.00	Dietary	39,370.00	13.55	34.00
35.00	Dietary under contract (see instructions)	0.00	0.00	35.00
36.00	Cafeteria	49,909.00	13.54	36.00
37.00	Maintenance of Personnel	0.00	0.00	37.00
38.00	Nursing Administration	41,274.00	30.28	38.00
39.00	Central Services and Supply	24,871.00	15.12	39.00
40.00	Pharmacy	33,675.00	32.40	40.00
41.00	Medical Records & Medical Records Library	80,121.00	17.15	41.00
42.00	Social Service	0.00	0.00	42.00
43.00	Other General Service	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140189

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

Worksheet S-3
Part III
Date/Time Prepared:
12/13/2011 3:00 pm

	Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	
	1.00	2.00	2.50	3.00	4.00	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)	74,989,700	0	0	74,989,700	1.00
2.00	Excluded area salaries (see instructions)	28,473,505	0	0	28,473,505	2.00
3.00	Subtotal salaries (line 1 minus line 2)	46,516,195	0	0	46,516,195	3.00
4.00	Subtotal other wages & related costs (see inst.)	52,360	0	0	52,360	4.00
5.00	Subtotal wage-related costs (see inst.)	22,475,454	0	0	22,475,454	5.00
6.00	Total (sum of lines 3 thru 5)	69,044,009	0	0	69,044,009	6.00
7.00	Total overhead cost (see instructions)	17,394,779	0	0	17,394,779	7.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part III Date/Time Prepared: 12/13/2011 3:00 pm
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		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY				
1.00	Net salaries (see instructions)	2,777,853.00	27.00	1.00
2.00	Excluded area salaries (see instructions)	736,519.00	38.66	2.00
3.00	Subtotal salaries (line 1 minus line 2)	2,041,334.00	22.79	3.00
4.00	Subtotal other wages & related costs (see inst.)	436.00	120.09	4.00
5.00	Subtotal wage-related costs (see inst.)	0.00	48.32	5.00
6.00	Total (sum of lines 3 thru 5)	2,041,770.00	33.82	6.00
7.00	Total overhead cost (see instructions)	771,406.00	22.55	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part IV Date/Time Prepared: 12/13/2011 3:00 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	4,152,341	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	10,509,111	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	630,241	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	285,587	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	21,019	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	166,502	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,433,973	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,909,966	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	246,789	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	34,752	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	22,390,281	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part V Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	OTHER (SPECIFY)	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-4
		Component CCN: 147594		Date/Time Prepared: 12/13/2011 3:00 pm
			Home Health Agency I	PPS

		1.00					
0.00	County	COLES					0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	971.00	115.00	344.00	1,430.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0	1.00	2.00	3.00		
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)		40.00	0.35	0.00	0.35	3.00
4.00	Director(s) and Assistant Director(s)			1.98	0.00	1.98	4.00
5.00	Other Administrative Personnel			11.55	0.00	11.55	5.00
6.00	Direct Nursing Service			22.80	0.00	22.80	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			4.91	0.00	4.91	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.31	0.00	1.31	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.49	0.00	0.49	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.77	0.00	0.77	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			3.71	0.00	3.71	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914				20.00
20.01			50031				20.01
20.02			50013				20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	10,653	860	354	187	12,054	21.00
22.00	Skilled Nursing Visit Charges	1,885,594	146,596	62,901	33,231	2,128,322	22.00
23.00	Physical Therapy Visits	3,715	52	43	78	3,888	23.00
24.00	Physical Therapy Visit Charges	697,327	9,464	7,948	14,562	729,301	24.00
25.00	Occupational Therapy Visits	931	13	3	19	966	25.00
26.00	Occupational Therapy Visit Charges	171,024	2,366	546	3,458	177,394	26.00
27.00	Speech Pathology Visits	146	0	1	6	153	27.00
28.00	Speech Pathology Visit Charges	26,572	0	182	1,092	27,846	28.00
29.00	Medical Social Service Visits	173	9	3	4	189	29.00
30.00	Medical Social Service Visit Charges	38,579	2,007	669	892	42,147	30.00
31.00	Home Health Aide Visits	2,691	95	4	23	2,813	31.00
32.00	Home Health Aide Visit Charges	209,898	7,410	312	1,794	219,414	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	18,309	1,029	408	317	20,063	33.00
34.00	Other Charges	18,309	1,029	408	317	20,063	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,047,303	168,872	72,966	55,346	3,344,487	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,164		149	26	1,339	36.00
37.00	Total Number of Outlier Episodes		22		0	22	37.00
38.00	Total Non-Routine Medical Supply Charges	106,798	9,354	8,802	314	125,268	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm
			Rural Health Clinic (RHC) I	Cost
				1.00
1.00	Clinic Address and Identification			1.00
	Street	412 NW 3RD		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	CASEY	IL	62420
				1.00
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
		Grant Award	Date	3.00
		1.00	2.00	
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00
				1.00
				2.00
10.00	Does this facility operate as other than an RHC or FOHC? 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
		N		10.00
				1.00
				2.00
Sunday				
	from	to	Monday	
	1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1)			11.00
	Clinic	08:00	17:00	
				1.00
				2.00
12.00	Have you received an approval for an exception to the productivity standard?			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			0
		N		13.00
Provider name				
	1.00			CCN number
				2.00
14.00	Provider name, CCN number			14.00
	Y/N	V	XVIII	XIX
	1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)			0
		0	0	0
				15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm Cost
		Rural Health Clinic (RHC) I		
		County		
		4.00		
2.00	City, State, Zip Code, County	CLARK		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 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	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm Cost
			Rural Health Clinic (RHC) I	
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm
			Rural Health Clinic (RHC) II	Cost
				1.00
1.00	Clinic Address and Identification Street		7 HAWTHORNE LANE	1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County		SULLIVAN	IL61951
				1.00
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
				3.00
				Grant Award
				Date
				1.00
				2.00
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)			0
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 FOHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0
10.00				
		Sunday		Monday
		from	to	from
		1.00	2.00	3.00
				4.00
11.00	Facility hours of operations (1) Clinic		08:00	17:00
				1.00
				2.00
12.00	Have you received an approval for an exception to the productivity standard?			0
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.			0
				12.00
				13.00
			Provider name	CCN number
			1.00	2.00
14.00	Provider name, CCN number			
		Y/N	V	XVIII
		1.00	2.00	3.00
				XIX
				4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		0	0
				0
				15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm
			Rural Health Clinic (RHC) II	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	MOULTRIE		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm Cost
		Rural Health Clinic (RHC) II	

	Thursday		Friday			
	from	to	from	to		
	9.00	10.00	11.00	12.00		
11.00	Facility hours of operations (1)	08:00	17:00	08:00	17:00	11.00
	Clinic					

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm
			Rural Health Clinic (RHC) II	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm
			Rural Health Clinic (RHC) III	Cost
				1.00
1.00	Clinic Address and Identification			1.00
	Street	650 OAK AVENUE		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	NEOGA	IL	62447
				1.00
3.00	FOHCs 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 FOHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N
		Sunday		Monday
		from	to	from
		1.00	2.00	3.00
				4.00
11.00	Facility hours of operations (1)			11.00
	Clinic	08:00	17:00	
				1.00
				2.00
12.00	Have you received an approval for an exception to the productivity standard?			N
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.			0
			Provider name	CCN number
			1.00	2.00
14.00	Provider name, CCN number			14.00
		Y/N	V	XVIII
		1.00	2.00	3.00
				XIX
				4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)			0
		0	0	0

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm
			Rural Health Clinic (RHC) III	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	CUMBERLAND		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm Cost
		Rural Health Clinic (RHC) III	

	Thursday		Friday				
	from	to	from	to			
	9.00	10.00	11.00	12.00			
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/13/2011 3:00 pm Cost
			Rural Health Clinic (RHC) III	
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140189	Period:	Worksheet S-9 Parts I & II Date/Time Prepared: 12/13/2011 3:00 pm
	Component CCN: 141599	From 07/01/2010 To 06/30/2011	
			Hospice I

	Unduplicated Days						
	Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
	1.00	2.00	3.00	4.00	5.00		
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	18,289	1,361	7,952	182	1,226	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	3.00
4.00	General Inpatient Care	0	0	0	0	0	4.00
5.00	Total Hospice Days	18,289	1,361	7,952	182	1,226	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	439	29	168	12	46	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	41.66	46.93	47.33	15.17	26.65	8.00
9.00	Unduplicated Census Count	0	0	0	0	0	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 140189 Component CCN: 141599	Period: From 07/01/2010 To 06/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 12/13/2011 3:00 pm
		Hospice I		

		Unduplicated Days		
		Total (sum of cols. 1, 2 & 5)		
		6.00		
PART I - ENROLLMENT DAYS				
1.00	Continuous Home Care	0		1.00
2.00	Routine Home Care	20,876		2.00
3.00	Inpatient Respite Care	0		3.00
4.00	General Inpatient Care	0		4.00
5.00	Total Hospice Days	20,876		5.00
Part II - CENSUS DATA				
6.00	Number of Patients Receiving Hospice Care	514		6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare			7.00
8.00	Average Length of Stay (line 5/line 6)	40.61		8.00
9.00	Unduplicated Census Count	0		9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 12/13/2011 3:00 pm
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				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)		0.309436		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		54,988,329		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		9,968,258		5.00	
6.00	Medicaid charges		63,659,492		6.00	
7.00	Medicaid cost (line 1 times line 6)		19,698,539		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)		0		8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP		0		9.00	
10.00	Stand-alone SCHIP charges		0		10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		1,324,449	54,510,468	55,834,917	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		409,832	16,867,501	17,277,333	21.00
22.00	Partial payment by patients approved for charity care		14,850	458,419	473,269	22.00
23.00	Cost of charity care (line 21 minus line 22)		394,982	16,409,082	16,804,064	23.00
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?					24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)				8,660,299	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				903,349	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)				7,756,950	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)				2,400,280	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)				19,204,344	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				19,204,344	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet A Date/Time Prepared: 12/13/2011 3:00 pm	
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		0	0	4,636,784	4,636,784	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0	0	8,529,137	8,529,137	2.00
4.00 EMPLOYEE BENEFITS	523,936	17,798,754	18,322,690	135,340	18,458,030	4.00
5.00 ADMINISTRATIVE & GENERAL	9,555,087	26,065,371	35,620,458	-14,340,488	21,279,970	5.00
7.00 OPERATION OF PLANT	935,738	2,849,201	3,784,939	-44,853	3,740,086	7.00
8.00 LAUNDRY & LINEN SERVICE	27,290	355,531	382,821	0	382,821	8.00
9.00 HOUSEKEEPING	1,052,164	336,669	1,388,833	0	1,388,833	9.00
10.00 DIETARY	1,209,398	950,504	2,159,902	-1,208,899	951,003	10.00
11.00 CAFETERIA	0	0	0	1,207,170	1,207,170	11.00
13.00 NURSING ADMINISTRATION	1,249,872	147,501	1,397,373	-1,772	1,395,601	13.00
14.00 CENTRAL SERVICES & SUPPLY	376,126	638,391	1,014,517	-19,967	994,550	14.00
15.00 PHARMACY	1,091,034	7,320,109	8,411,143	-7,110,054	1,301,089	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,374,134	580,066	1,954,200	-6,741	1,947,459	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	7,894,847	1,053,404	8,948,251	-900,533	8,047,718	30.00
32.00 CORONARY CARE UNIT	1,131,501	163,581	1,295,082	-329	1,294,753	32.00
40.00 SUBPROVIDER - IPF	2,090,186	227,570	2,317,756	12,758	2,330,514	40.00
43.00 NURSERY	0	11,172	11,172	356,969	368,141	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,824,476	673,457	3,497,933	-4,722	3,493,211	50.00
51.00 RECOVERY ROOM	665,455	125,236	790,691	-4,612	786,079	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	68,109	68,109	541,723	609,832	52.00
53.00 ANESTHESIOLOGY	4,265,338	537,150	4,802,488	445,703	5,248,191	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,653,962	740,950	2,394,912	-255,089	2,139,823	54.00
55.00 RADIOLOGY-THERAPEUTIC	1,608,553	375,191	1,983,744	23,016	2,006,760	55.00
56.00 RADIOISOTOPE	750,792	893,085	1,643,877	143,278	1,787,155	56.00
57.00 CT SCAN	305,243	706,090	1,011,333	63,915	1,075,248	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	230,563	409,561	640,124	46,234	686,358	58.00
59.00 CARDIAC CATHETERIZATION	583,550	206,325	789,875	-68	789,807	59.00
60.00 LABORATORY	3,989,005	4,923,398	8,912,403	6,593	8,918,996	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	753,349	227,030	980,379	-4,005	976,374	65.00
66.00 PHYSICAL THERAPY	1,361,686	271,805	1,633,491	-13,434	1,620,057	66.00
67.00 OCCUPATIONAL THERAPY	244,079	38,746	282,825	0	282,825	67.00
68.00 SPEECH PATHOLOGY	613,256	107,062	720,318	-1,087	719,231	68.00
69.00 ELECTROCARDIOLOGY	1,499,855	718,424	2,218,279	38,106	2,256,385	69.00
70.00 ELECTROENCEPHALOGRAPHY	307,866	585,653	893,519	-3,119	890,400	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,321,970	3,321,970	0	3,321,970	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	3,082,957	3,082,957	0	3,082,957	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	6,973,198	6,973,198	73.00
75.00 ASC (NON-DISTINCT PART)	1,348,373	887,239	2,235,612	-10,133	2,225,479	75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	410,697	40,909	451,606	-11,361	440,245	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	342,346	106,013	448,359	19,655	468,014	88.00
88.01 RURAL HEALTH CLINIC II	355,327	118,709	474,036	15,879	489,915	88.01
88.02 RURAL HEALTH CLINIC III	428,882	99,041	527,923	19,704	547,627	88.02
91.00 EMERGENCY	6,438,133	907,127	7,345,260	239,995	7,585,255	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	2,463,025	689,089	3,152,114	-15,577	3,136,537	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	1,119,500	843,189	1,962,689	-163,994	1,798,695	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	63,074,624	80,201,339	143,275,963	-665,680	142,610,283	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	21,563,018	4,459,083	26,022,101	796,504	26,818,605	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 WELLNESS	98,703	79,835	178,538	0	178,538	194.01
194.02 LIFELINE	34,419	122,948	157,367	0	157,367	194.02
194.03 OCCUPATIONAL HEALTH	428,529	169,205	597,734	-130,824	466,910	194.03
194.05 MIS. NONREIMBURSABLE	676,125	587,304	1,263,429	0	1,263,429	194.05
200.00 TOTAL (SUM OF LINES 118-199)	85,875,418	85,619,714	171,495,132	0	171,495,132	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet A Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-1,934,387	2,702,397	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-228,025	8,301,112	2.00
4.00	EMPLOYEE BENEFITS	-84,881	18,373,149	4.00
5.00	ADMINISTRATIVE & GENERAL	-215,233	21,064,737	5.00
7.00	OPERATION OF PLANT	-223	3,739,863	7.00
8.00	LAUNDRY & LINEN SERVICE	0	382,821	8.00
9.00	HOUSEKEEPING	-155	1,388,678	9.00
10.00	DIETARY	-10,869	940,134	10.00
11.00	CAFETERIA	-679,270	527,900	11.00
13.00	NURSING ADMINISTRATION	0	1,395,601	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	994,550	14.00
15.00	PHARMACY	0	1,301,089	15.00
16.00	MEDICAL RECORDS & LIBRARY	-82,743	1,864,716	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-350,781	7,696,937	30.00
32.00	CORONARY CARE UNIT	0	1,294,753	32.00
40.00	SUBPROVIDER - IPF	-1,131,179	1,199,335	40.00
43.00	NURSERY	0	368,141	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	3,493,211	50.00
51.00	RECOVERY ROOM	0	786,079	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	609,832	52.00
53.00	ANESTHESIOLOGY	-4,598,002	650,189	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-8,568	2,131,255	54.00
55.00	RADIOLOGY-THERAPEUTIC	-1,015,668	991,092	55.00
56.00	RADIOISOTOPE	0	1,787,155	56.00
57.00	CT SCAN	-1,850	1,073,398	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	686,358	58.00
59.00	CARDIAC CATHETERIZATION	0	789,807	59.00
60.00	LABORATORY	-650,203	8,268,793	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	0	976,374	65.00
66.00	PHYSICAL THERAPY	-9,075	1,610,982	66.00
67.00	OCCUPATIONAL THERAPY	8,938	291,763	67.00
68.00	SPEECH PATHOLOGY	-583,260	135,971	68.00
69.00	ELECTROCARDIOLOGY	-1,377,521	878,864	69.00
70.00	ELECTROENCEPHALOGRAPHY	-429,706	460,694	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,321,970	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	3,082,957	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	6,973,198	73.00
75.00	ASC (NON-DISTINCT PART)	0	2,225,479	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	440,245	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	468,014	88.00
88.01	RURAL HEALTH CLINIC II	0	489,915	88.01
88.02	RURAL HEALTH CLINIC III	0	547,627	88.02
91.00	EMERGENCY	-3,817,312	3,767,943	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	3,136,537	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	0	1,798,695	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-17,199,973	125,410,310	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	26,818,605	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	WELLNESS	0	178,538	194.01
194.02	LIFELINE	0	157,367	194.02
194.03	OCCUPATIONAL HEALTH	0	466,910	194.03
194.05	MISC. NONREIMBURSABLE	0	1,263,429	194.05
200.00	TOTAL (SUM OF LINES 118-199)	-17,199,973	154,295,159	200.00

RECLASSIFICATIONS

Provider CCN: 140189

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

Worksheet A-6

Date/Time Prepared:
12/13/2011 3:00 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,973,198	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	
	TOTALS		0	6,973,198		
B - RADIOLOGY ADMIN EXPENSES						
1.00	RADIOISOTOPE	56.00	128,531	14,747	1.00	
2.00	CT SCAN	57.00	52,256	11,659	2.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	39,471	6,763	3.00	
	TOTALS		220,258	33,169		
C - CAPITAL COSTS: EQUIP RENTAL/COPIERS						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	566,079	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
	TOTALS		0	566,079		
D - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,630,614	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	7,651,492	2.00	
	TOTALS		0	10,282,106		
E - CAFETERIA						
1.00	CAFETERIA	11.00	675,933	531,237	1.00	
	TOTALS		675,933	531,237		
F - EMPLOYEE PHYSICALS						
1.00	EMPLOYEE BENEFITS	4.00	0	129,600	1.00	
	TOTALS		0	129,600		
G - EAP BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	0	11,361	1.00	
	TOTALS		0	11,361		
H - PHYSN PROF LIABILITY EXP						
1.00	ADULTS & PEDIATRICS	30.00	0	11,285	1.00	
2.00	SUBPROVIDER - I PF	40.00	0	13,615	2.00	
3.00	ANESTHESIOLOGY	53.00	0	449,278	3.00	
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	25,383	4.00	
5.00	LABORATORY	60.00	0	13,615	5.00	
6.00	ELECTROCARDIOLOGY	69.00	0	40,844	6.00	
7.00	EMERGENCY	91.00	0	246,811	7.00	
8.00	RURAL HEALTH CLINIC	88.00	0	20,422	8.00	
9.00	RURAL HEALTH CLINIC II	88.01	0	16,825	9.00	

RECLASSIFICATIONS

Provider CCN: 140189

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

Worksheet A-6

Date/Time Prepared:
12/13/2011 3:00 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
10.00	RURAL HEALTH CLINIC III	88.02	0	20,422	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	838,360	11.00
	TOTALS		0	1,696,860	
I - DEFAULT					
1.00	NURSERY	43.00	356,969	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	541,723	0	2.00
	TOTALS		898,692	0	
J - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	2,006,170	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	311,566	2.00
	TOTALS		0	2,317,736	
500.00	Grand Total: Increases		1,794,883	22,541,346	500.00

RECLASSIFICATIONS

Provider CCN: 140189

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

Worksheet A-6

Date/Time Prepared:
12/13/2011 3:00 pm

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	6,963,192	0	1.00	
2.00	OPERATING ROOM	50.00	0	432	0	2.00	
3.00	RECOVERY ROOM	51.00	0	3,270	0	3.00	
4.00	ANESTHESIOLOGY	53.00	0	3,575	0	4.00	
5.00	ASC (NON-DISTINCT PART)	75.00	0	2,693	0	5.00	
6.00	EMERGENCY	91.00	0	19	0	6.00	
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17	0	7.00	
TOTALS			0	6,973,198			
B - RADIOLOGY ADMIN EXPENSES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	220,258	33,169	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
TOTALS			220,258	33,169			
C - CAPITAL COSTS: EQUIP RENTAL/COPIERS							
1.00	EMPLOYEE BENEFITS	4.00	0	5,621	14	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	43,786	14	2.00	
3.00	OPERATION OF PLANT	7.00	0	44,853	14	3.00	
4.00	DIETARY	10.00	0	1,729	14	4.00	
5.00	NURSING ADMINISTRATION	13.00	0	1,772	14	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,967	14	6.00	
7.00	PHARMACY	15.00	0	146,862	14	7.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,741	14	8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	13,126	14	9.00	
10.00	CORONARY CARE UNIT	32.00	0	329	14	10.00	
11.00	SUBPROVIDER - IPF	40.00	0	857	14	11.00	
12.00	OPERATING ROOM	50.00	0	4,290	14	12.00	
13.00	RECOVERY ROOM	51.00	0	1,342	14	13.00	
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,645	14	14.00	
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,367	14	15.00	
16.00	LABORATORY	60.00	0	7,022	14	16.00	
17.00	RESPIRATORY THERAPY	65.00	0	4,005	14	17.00	
18.00	PHYSICAL THERAPY	66.00	0	13,434	14	18.00	
19.00	SPEECH PATHOLOGY	68.00	0	1,087	14	19.00	
20.00	ELECTROCARDIOLOGY	69.00	0	2,738	14	20.00	
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,119	14	21.00	
22.00	ASC (NON-DISTINCT PART)	75.00	0	7,440	14	22.00	
23.00	CARDIAC CATHETERIZATION	59.00	0	68	14	23.00	
24.00	EMERGENCY	91.00	0	6,797	14	24.00	
25.00	RURAL HEALTH CLINIC	88.00	0	767	14	25.00	
26.00	RURAL HEALTH CLINIC II	88.01	0	946	14	26.00	
27.00	RURAL HEALTH CLINIC III	88.02	0	718	14	27.00	
28.00	HOME HEALTH AGENCY	101.00	0	15,577	14	28.00	
29.00	HOSPICE	116.00	0	163,994	14	29.00	
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	41,856	14	30.00	
31.00	OCCUPATIONAL HEALTH	194.03	0	1,224	14	31.00	
TOTALS			0	566,079			
D - DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,282,106	9	1.00	
2.00		0.00	0	0	9	2.00	
TOTALS			0	10,282,106			
E - CAFETERIA							
1.00	DIETARY	10.00	675,933	531,237	0	1.00	
TOTALS			675,933	531,237			
F - EMPLOYEE PHYSICALS							
1.00	OCCUPATIONAL HEALTH	194.03	0	129,600	0	1.00	
TOTALS			0	129,600			
G - EAP BENEFITS							
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	11,361	0	1.00	
TOTALS			0	11,361			
H - PHYSN PROF LIABILITY EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,696,860	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
8.00		0.00	0	0	0	8.00	
9.00		0.00	0	0	0	9.00	
10.00		0.00	0	0	0	10.00	
11.00		0.00	0	0	0	11.00	
TOTALS			0	1,696,860			

RECLASSIFICATIONS

Provider CCN: 140189

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

Worksheet A-6

Date/Time Prepared:
12/13/2011 3:00 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
I - DEFAULT							
1.00	ADULTS & PEDIATRICS	30.00	898,692	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		898,692	0			
J - INTEREST							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,317,736	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	2,317,736			
500.00	Grand Total: Decreases		1,794,883	22,541,346			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet A-7 Parts I-III Date/Time Prepared: 12/13/2011 3:00 pm
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		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	2,826,301	367,968	0	367,968	0	1.00
2.00	Land Improvements	4,072,754	2,233,545	0	2,233,545	0	2.00
3.00	Buildings and Fixtures	60,000,409	8,701,531	0	8,701,531	100,153	3.00
4.00	Building Improvements	227,640	0	0	0	121,808	4.00
5.00	Fixed Equipment	13,680,815	273,952	0	273,952	0	5.00
6.00	Movable Equipment	72,782,899	4,825,787	0	4,825,787	2,657,120	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	153,590,818	16,402,783	0	16,402,783	2,879,081	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	153,590,818	16,402,783	0	16,402,783	2,879,081	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	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL	Insurance	
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)		
		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	78,974,814	0	78,974,814	0.479501	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	88,139,706	2,412,543	85,727,163	0.520499	0	2.00
3.00	Total (sum of lines 1-2)	167,114,520	2,412,543	164,701,977	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
12/13/2011 3:00 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,194,269	0		1.00		
2.00	Land Improvements	6,306,299	0		2.00		
3.00	Buildings and Fixtures	68,601,787	0		3.00		
4.00	Building Improvements	105,832	0		4.00		
5.00	Fixed Equipment	13,954,767	0		5.00		
6.00	Movable Equipment	74,951,566	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	167,114,520	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	167,114,520	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	0		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	0		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	2,630,614	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	7,651,492	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,282,106	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
12/13/2011 3:00 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	71,783	0	0	0	2,702,397	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	83,541	0	0	566,079	8,301,112	2.00
3.00	Total (sum of lines 1-2)	155,324	0	0	566,079	11,003,509	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140189

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

Worksheet A-8

Date/Time Prepared:
12/13/2011 3:00 pm

				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)			NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	Investment income - movable equipment (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00
3.00	Investment income - other (chapter 2)		0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		7.00
8.00	Television and radio service (chapter 21)		0		8.00
9.00	Parking lot (chapter 21)		0		9.00
10.00	Provider-based physician adjustment	A-8-2	-11,533,291		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0		12.00
13.00	Laundry and linen service		0		13.00
14.00	Cafeteria-employees and guests	B	-679,270	CAFETERIA	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	B	-82,743	MEDICAL RECORDS & LIBRARY	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		19.00
20.00	Vending machines	B	-155	HOUSEKEEPING	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)	A-8-3		ORESPIRATORY THERAPY	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	25.00
26.00	Depreciation - buildings and fixtures			NEW CAP REL COSTS-BLDG & FIXT	26.00
27.00	Depreciation - movable equipment			NEW CAP REL COSTS-MVBLE EQUIP	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	28.00
29.00	Physicians' assistant			0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	32.00
33.00	INVESTMENT INCOME	B	-1,468,248	NEW CAP REL COSTS-BLDG & FIXT	33.00
34.00	INVESTMENT INCOME	B	-228,025	NEW CAP REL COSTS-MVBLE EQUIP	34.00
35.00	A&G OTHER INCOME	B	-189,872	ADMINISTRATIVE & GENERAL	35.00
36.00	DIETARY OUTREACH REVENUE	B	-10,869	DIETARY	36.00
37.00	FACILITIES SVC OTHER REV	B	-223	OPERATION OF PLANT	37.00
38.00	W&C OTHER REV (BABY CLASSES)	B	-5,300	ADULTS & PEDIATRICS	38.00
39.00	XRAY OTHER REVENUE	B	-652	RADIOLOGY-DIAGNOSTIC	39.00
41.00	PHYSICAL THERAPY OTHER REV	B	-9,075	PHYSICAL THERAPY	41.00
42.00	OCCUPATIONAL THPY OTR REV	B	8,938	OCCUPATIONAL THERAPY	42.00
43.00	SPEECH/AUDIO OTHER REV	B	-583,260	SPEECH PATHOLOGY	43.00
44.00	CARDIOLOGY OTHER REV	B	-66,413	ELECTROCARDIOLOGY	44.00
45.00	EMERGENCY (EMS) OTHER REV	B	-142,447	EMERGENCY	45.00
45.01	AHA/IHA LOBBYING FEES	A	-25,361	ADMINISTRATIVE & GENERAL	45.01
45.02	CRNA S&W (EMPLOYEES & LOCUM TENENS)	A	-1,632,687	ANESTHESIOLOGY	45.02
45.03	CRNA (BENEFIT EXP)	A	-84,881	EMPLOYEE BENEFITS	45.03
45.04	NON-ALLOWABLE INTEREST EXPENSE	A	-466,139	NEW CAP REL COSTS-BLDG & FIXT	45.04

Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8 Date/Time Prepared: 12/13/2011 3:00 pm
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		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
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,199,973		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140189

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

Worksheet A-8

Date/Time Prepared:
12/13/2011 3:00 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)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	INVESTMENT INCOME	11	33.00
34.00	INVESTMENT INCOME	11	34.00
35.00	A&G OTHER INCOME	0	35.00
36.00	DIETARY OUTREACH REVENUE	0	36.00
37.00	FACILITIES SVC OTHER REV	0	37.00
38.00	W&C OTHER REV (BABY CLASSES)	0	38.00
39.00	XRAY OTHER REVENUE	0	39.00
41.00	PHYSICAL THERAPY OTHER REV	0	41.00
42.00	OCCUPATIONAL THPY OTR REV	0	42.00
43.00	SPEECH/AUDIO OTHER REV	0	43.00
44.00	CARDIOLOGY OTHER REV	0	44.00
45.00	EMERGENCY (EMS) OTHER REV	0	45.00
45.01	AHA/IHA LOBBYING FEES	0	45.01
45.02	CRNA S&W (EMPLOYEES & LOCUM TENENS)	0	45.02
45.03	CRNA (BENEFIT EXP)	0	45.03
45.04	NON-ALLOWABLE INTEREST EXPENSE	11	45.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140189

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

Worksheet A-8-2

Date/Time Prepared:
12/13/2011 3:00 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		30.00	HOSPITALIST	370,019	307,383	1.00
2.00		40.00	PSYCH PHYSNS	1,131,179	1,131,179	2.00
3.00		53.00	ANESTHESIA PHYSNS	3,083,353	2,846,601	3.00
4.00		54.00	RADIOLOGY DIAG	7,916	7,916	4.00
5.00		55.00	RADIOLOGY THERA (ONCOLOGY)	1,015,668	1,015,668	5.00
6.00		57.00	CT SCANNING	1,850	1,850	6.00
7.00		60.00	LABORATORY/PATHOLOGY	695,962	618,899	7.00
8.00		69.00	CARDIOLOGY	1,311,108	1,311,108	8.00
9.00		70.00	NEUROLOGY	429,706	429,706	9.00
10.00		91.00	EMERGENCY ROOM	3,768,480	3,590,301	10.00
200.00			TOTAL (lines 1.00 through 199.00)	11,815,241	11,260,611	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140189

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

Worksheet A-8-2

Date/Time Prepared:
12/13/2011 3:00 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	62,636	138,700	324	21,605	1,080	1.00
2.00	0	138,700	0	0	0	2.00
3.00	236,752	167,500	988	79,563	3,978	3.00
4.00	0	217,600	0	0	0	4.00
5.00	0	217,600	0	0	0	5.00
6.00	0	217,600	0	0	0	6.00
7.00	77,063	208,000	439	43,900	2,195	7.00
8.00	0	159,800	0	0	0	8.00
9.00	0	159,800	0	0	0	9.00
10.00	178,179	159,800	1,040	79,900	3,995	10.00
200.00	554,630		2,791	224,968	11,248	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140189

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

Worksheet A-8-2

Date/Time Prepared:
12/13/2011 3:00 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	6,044	1,023	11,285	1,910	24,538	1.00
2.00	13,151	0	13,615	0	0	2.00
3.00	63,724	4,893	449,278	34,497	118,038	3.00
4.00	0	0	0	0	0	4.00
5.00	3,221	0	25,383	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	3,170	351	13,615	1,508	45,759	7.00
8.00	1,942	0	40,844	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	43,242	2,045	246,811	11,670	93,615	10.00
200.00	134,494	8,312	800,831	49,585	281,950	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140189

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

Worksheet A-8-2
Date/Time Prepared:
12/13/2011 3:00 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	38,098	345,481	1.00
2.00	0	1,131,179	2.00
3.00	118,714	2,965,315	3.00
4.00	0	7,916	4.00
5.00	0	1,015,668	5.00
6.00	0	1,850	6.00
7.00	31,304	650,203	7.00
8.00	0	1,311,108	8.00
9.00	0	429,706	9.00
10.00	84,564	3,674,865	10.00
200.00	272,680	11,533,291	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

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

Worksheet B
Part I
Date/Time Prepared:
12/13/2011 3:00 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	2,702,397	2,702,397				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	8,301,112		8,301,112			2.00
4.00 EMPLOYEE BENEFITS	18,373,149	20,663	2,671	18,396,483		4.00
5.00 ADMINISTRATIVE & GENERAL	21,064,737	289,738	1,652,145	2,059,484	25,066,104	5.00
7.00 OPERATION OF PLANT	3,739,863	203,542	105,475	201,687	4,250,567	7.00
8.00 LAUNDRY & LINEN SERVICE	382,821	7,049	0	5,882	395,752	8.00
9.00 HOUSEKEEPING	1,388,678	42,421	7,416	226,781	1,665,296	9.00
10.00 DIETARY	940,134	43,569	25,320	114,982	1,124,005	10.00
11.00 CAFETERIA	527,900	26,371	31,287	145,689	731,247	11.00
13.00 NURSING ADMINISTRATION	1,395,601	9,405	7,752	269,395	1,682,153	13.00
14.00 CENTRAL SERVICES & SUPPLY	994,550	42,341	137,582	81,069	1,255,542	14.00
15.00 PHARMACY	1,301,089	17,490	39,244	235,159	1,592,982	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,864,716	26,623	16,121	296,178	2,203,638	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	7,696,937	222,300	258,636	1,507,937	9,685,810	30.00
32.00 CORONARY CARE UNIT	1,294,753	29,418	52,158	243,881	1,620,210	32.00
40.00 SUBPROVIDER - IPF	1,199,335	57,860	13,466	450,515	1,721,176	40.00
43.00 NURSERY	368,141	4,095	9,368	76,940	458,544	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	3,493,211	160,358	587,032	608,782	4,849,383	50.00
51.00 RECOVERY ROOM	786,079	10,441	34,568	143,431	974,519	51.00
52.00 DELIVERY ROOM & LABOR ROOM	609,832	9,339	36,980	116,762	772,913	52.00
53.00 ANESTHESIOLOGY	650,189	4,288	71,847	919,342	1,645,666	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,131,255	89,846	917,545	309,018	3,447,664	54.00
55.00 RADIOLOGY-THERAPEUTIC	991,092	45,414	303,308	346,704	1,686,518	55.00
56.00 RADIOISOTOPE	1,787,155	12,930	2,212,296	189,528	4,201,909	56.00
57.00 CT SCAN	1,073,398	10,129	462,630	77,055	1,623,212	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	686,358	13,561	336,061	58,203	1,094,183	58.00
59.00 CARDIAC CATHETERIZATION	789,807	18,864	18,329	125,777	952,777	59.00
60.00 LABORATORY	8,268,793	58,862	281,734	859,782	9,469,171	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	976,374	10,255	31,814	162,375	1,180,818	65.00
66.00 PHYSICAL THERAPY	1,610,982	51,289	19,022	293,495	1,974,788	66.00
67.00 OCCUPATIONAL THERAPY	291,763	0	1,566	52,608	345,937	67.00
68.00 SPEECH PATHOLOGY	135,971	16,740	16,086	132,180	300,977	68.00
69.00 ELECTROCARDIOLOGY	878,864	38,053	114,180	323,276	1,354,373	69.00
70.00 ELECTROENCEPHALOGRAPHY	460,694	30,473	27,961	66,357	585,485	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,321,970	0	0	0	3,321,970	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,082,957	0	0	0	3,082,957	72.00
73.00 DRUGS CHARGED TO PATIENTS	6,973,198	0	0	0	6,973,198	73.00
75.00 ASC (NON-DISTINCT PART)	2,225,479	71,839	113,039	290,626	2,700,983	75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	440,245	18,048	3,111	88,521	549,925	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	468,014	94,546	9,737	73,789	646,086	88.00
88.01 RURAL HEALTH CLINIC II	489,915	46,072	1,330	76,586	613,903	88.01
88.02 RURAL HEALTH CLINIC III	547,627	18,791	1,597	92,440	660,455	88.02
91.00 EMERGENCY	3,767,943	59,632	49,346	1,387,662	5,264,583	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	3,136,537	21,745	3,153	530,875	3,692,310	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	1,798,695	15,532	423	241,295	2,055,945	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	125,410,310	1,969,932	8,013,336	13,482,048	119,475,634	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	26,818,605	589,498	135,613	4,647,647	32,191,363	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 WELLNESS	178,538	0	1,634	21,274	201,446	194.01
194.02 LI FELINE	157,367	1,593	0	7,419	166,379	194.02
194.03 OCCUPATIONAL HEALTH	466,910	19,322	6,366	92,364	584,962	194.03
194.05 MIS. NONREIMBURSABLE	1,263,429	122,052	144,163	145,731	1,675,375	194.05
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	154,295,159	2,702,397	8,301,112	18,396,483	154,295,159	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140189		Period: From 07/01/2010 To 06/30/2011		Worksheet B Part I Date/Time Prepared: 12/13/2011 3:00 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	25,066,104					5.00
7.00	OPERATION OF PLANT	824,465	5,075,032				7.00
8.00	LAUNDRY & LINEN SERVICE	76,762	16,347	488,861			8.00
9.00	HOUSEKEEPING	323,011	98,374	0	2,086,681		9.00
10.00	DIETARY	218,019	101,037	2,981	0	1,446,042	10.00
11.00	CAFETERIA	141,837	61,155	0	110,943	0	11.00
13.00	NURSING ADMINISTRATION	326,280	21,811	0	27,736	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	243,532	98,189	14,373	20,064	0	14.00
15.00	PHARMACY	308,984	40,559	0	20,064	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	427,431	61,740	0	18,884	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,878,718	515,513	162,409	33,637	1,141,733	30.00
32.00	CORONARY CARE UNIT	314,266	68,220	16,115	101,501	56,270	32.00
40.00	SUBPROVIDER - I/PF	333,850	134,177	9,155	0	199,456	40.00
43.00	NURSERY	88,942	9,497	4,962	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	940,615	371,870	62,943	267,326	27,471	50.00
51.00	RECOVERY ROOM	189,024	24,213	12,826	54,882	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	149,919	21,657	9,995	0	0	52.00
53.00	ANESTHESIOLOGY	319,203	9,944	0	14,163	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	668,730	208,354	50,542	46,620	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	327,127	105,316	5,493	61,373	0	55.00
56.00	RADIOISOTOPE	815,027	29,985	34	16,523	0	56.00
57.00	CT SCAN	314,848	23,489	0	12,393	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	212,234	31,447	0	20,654	0	58.00
59.00	CARDIAC CATHETERIZATION	184,806	43,746	2,600	0	0	59.00
60.00	LABORATORY	1,836,697	136,502	62	80,847	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	229,039	23,782	0	17,114	0	65.00
66.00	PHYSICAL THERAPY	383,042	118,939	8,075	92,059	0	66.00
67.00	OCCUPATIONAL THERAPY	67,100	0	0	3,541	0	67.00
68.00	SPEECH PATHOLOGY	58,379	38,820	0	5,901	0	68.00
69.00	ELECTROCARDIOLOGY	262,702	88,246	4,850	27,146	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	113,564	70,667	1,064	25,375	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	644,349	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	597,989	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,352,563	0	0	0	0	73.00
75.00	ASC (NON-DISTINCT PART)	523,899	166,594	34,009	196,512	0	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	106,667	41,852	0	18,884	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	125,319	219,252	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	119,076	106,840	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	128,106	43,576	0	0	0	88.02
91.00	EMERGENCY	1,021,150	138,287	85,939	339,323	21,112	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	716,183	50,426	0	12,983	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	398,783	36,019	0	9,442	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,312,237	3,376,442	488,427	1,655,890	1,446,042	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	6,244,092	1,367,049	0	309,815	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	WELLNESS	39,074	0	0	3,541	0	194.01
194.02	LIFELINE	32,272	3,694	0	0	0	194.02
194.03	OCCUPATIONAL HEALTH	113,463	44,808	434	21,835	0	194.03
194.05	MISC. NONREIMBURSABLE	324,966	283,039	0	95,600	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	25,066,104	5,075,032	488,861	2,086,681	1,446,042	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140189		Period: From 07/01/2010 To 06/30/2011		Worksheet B Part I Date/Time Prepared: 12/13/2011 3:00 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	1,045,182					11.00
13.00	NURSING ADMINISTRATION	23,047	2,081,027				13.00
14.00	CENTRAL SERVICES & SUPPLY	13,828	0	1,645,528			14.00
15.00	PHARMACY	18,438	0	0	1,981,027		15.00
16.00	MEDICAL RECORDS & LIBRARY	44,942	0	0	0	2,756,635	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	179,766	947,020	0	0	171,675	30.00
32.00	CORONARY CARE UNIT	23,047	121,000	0	0	21,929	32.00
40.00	SUBPROVIDER - IPF	25,352	114,957	0	0	27,909	40.00
43.00	NURSERY	8,066	47,015	0	0	9,625	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	62,227	330,491	0	0	152,292	50.00
51.00	RECOVERY ROOM	12,676	70,243	0	0	31,115	51.00
52.00	DELIVERY ROOM & LABOR ROOM	11,524	67,065	0	0	30,806	52.00
53.00	ANESTHESIOLOGY	20,742	20,223	0	0	60,714	53.00
54.00	RADIOLOGY-DIAGNOSTIC	33,418	0	0	0	143,809	54.00
55.00	RADIOLOGY-THERAPEUTIC	14,981	0	0	0	51,072	55.00
56.00	RADIOISOTOPE	13,828	0	0	0	112,508	56.00
57.00	CT SCAN	6,914	0	0	0	249,907	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	4,609	0	0	0	98,825	58.00
59.00	CARDIAC CATHETERIZATION	6,914	0	0	0	11,095	59.00
60.00	LABORATORY	99,102	0	0	0	393,295	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	17,285	0	0	0	53,979	65.00
66.00	PHYSICAL THERAPY	17,285	0	0	0	51,258	66.00
67.00	OCCUPATIONAL THERAPY	4,609	0	0	0	7,437	67.00
68.00	SPEECH PATHOLOGY	11,524	0	0	0	12,154	68.00
69.00	ELECTROCARDIOLOGY	19,590	0	0	0	35,333	69.00
70.00	ELECTROENCEPHALOGRAPHY	9,219	0	0	0	36,190	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	740,488	0	133,963	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	905,040	0	89,738	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	1,981,027	343,349	73.00
75.00	ASC (NON-DISTINCT PART)	31,113	0	0	0	167,099	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,524	0	0	0	1,516	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	3,810	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	2,780	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	0	6,716	88.02
91.00	EMERGENCY	76,055	363,013	0	0	244,737	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	21,895	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	19,590	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	863,110	2,081,027	1,645,528	1,981,027	2,756,635	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	160,177	0	0	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	9,219	0	0	0	0	194.00
194.01	WELLNESS	3,457	0	0	0	0	194.01
194.02	LIFELINE	0	0	0	0	0	194.02
194.03	OCCUPATIONAL HEALTH	9,219	0	0	0	0	194.03
194.05	MISC. NONREIMBURSABLE	0	0	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,045,182	2,081,027	1,645,528	1,981,027	2,756,635	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

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

Worksheet B
Part I
Date/Time Prepared:
12/13/2011 3:00 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
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	14,716,281	0	14,716,281	30.00
32.00	CORONARY CARE UNIT	2,342,558	0	2,342,558	32.00
40.00	SUBPROVIDER - IPF	2,566,032	0	2,566,032	40.00
43.00	NURSERY	626,651	0	626,651	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	7,064,618	0	7,064,618	50.00
51.00	RECOVERY ROOM	1,369,498	0	1,369,498	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,063,879	0	1,063,879	52.00
53.00	ANESTHESIOLOGY	2,090,655	0	2,090,655	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,599,137	0	4,599,137	54.00
55.00	RADIOLOGY-THERAPEUTIC	2,251,880	0	2,251,880	55.00
56.00	RADIOISOTOPE	5,189,814	0	5,189,814	56.00
57.00	CT SCAN	2,230,763	0	2,230,763	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	1,461,952	0	1,461,952	58.00
59.00	CARDIAC CATHETERIZATION	1,201,938	0	1,201,938	59.00
60.00	LABORATORY	12,015,676	0	12,015,676	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
65.00	RESPIRATORY THERAPY	1,522,017	0	1,522,017	65.00
66.00	PHYSICAL THERAPY	2,645,446	0	2,645,446	66.00
67.00	OCCUPATIONAL THERAPY	428,624	0	428,624	67.00
68.00	SPEECH PATHOLOGY	427,755	0	427,755	68.00
69.00	ELECTROCARDIOLOGY	1,792,240	0	1,792,240	69.00
70.00	ELECTROENCEPHALOGRAPHY	841,564	0	841,564	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,840,770	0	4,840,770	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,675,724	0	4,675,724	72.00
73.00	DRUGS CHARGED TO PATIENTS	10,650,137	0	10,650,137	73.00
75.00	ASC (NON-DISTINCT PART)	3,820,209	0	3,820,209	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	730,368	0	730,368	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	994,467	0	994,467	88.00
88.01	RURAL HEALTH CLINIC II	842,599	0	842,599	88.01
88.02	RURAL HEALTH CLINIC III	838,853	0	838,853	88.02
91.00	EMERGENCY	7,554,199	0	7,554,199	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY	4,493,797	0	4,493,797	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	HOSPICE	2,519,779	0	2,519,779	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	110,409,880	0	110,409,880	118.00
NONREIMBURSABLE COST CENTERS					
192.00	PHYSICIANS' PRIVATE OFFICES	40,272,496	0	40,272,496	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	9,219	0	9,219	194.00
194.01	WELLNESS	247,518	0	247,518	194.01
194.02	LIFELINE	202,345	0	202,345	194.02
194.03	OCCUPATIONAL HEALTH	774,721	0	774,721	194.03
194.05	MISC. NONREIMBURSABLE	2,378,980	0	2,378,980	194.05
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)	154,295,159	0	154,295,159	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part II Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS		
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		0	1.00				2.00
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	20,663	2,671	23,334	23,334	4.00
5.00	ADMINISTRATIVE & GENERAL	0	289,738	1,652,145	1,941,883	2,609	5.00
7.00	OPERATION OF PLANT	0	203,542	105,475	309,017	255	7.00
8.00	LAUNDRY & LINEN SERVICE	0	7,049	0	7,049	7	8.00
9.00	HOUSEKEEPING	0	42,421	7,416	49,837	287	9.00
10.00	DIETARY	0	43,569	25,320	68,889	146	10.00
11.00	CAFETERIA	0	26,371	31,287	57,658	185	11.00
13.00	NURSING ADMINISTRATION	0	9,405	7,752	17,157	341	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	42,341	137,582	179,923	103	14.00
15.00	PHARMACY	0	17,490	39,244	56,734	298	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	26,623	16,121	42,744	375	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	222,300	258,636	480,936	1,910	30.00
32.00	CORONARY CARE UNIT	0	29,418	52,158	81,576	309	32.00
40.00	SUBPROVIDER - I/PF	0	57,860	13,466	71,326	571	40.00
43.00	NURSERY	0	4,095	9,368	13,463	97	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	160,358	587,032	747,390	771	50.00
51.00	RECOVERY ROOM	0	10,441	34,568	45,009	182	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	9,339	36,980	46,319	148	52.00
53.00	ANESTHESIOLOGY	0	4,288	71,847	76,135	1,164	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	89,846	917,545	1,007,391	391	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	45,414	303,308	348,722	439	55.00
56.00	RADIOISOTOPE	0	12,930	2,212,296	2,225,226	240	56.00
57.00	CT SCAN	0	10,129	462,630	472,759	98	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	13,561	336,061	349,622	74	58.00
59.00	CARDIAC CATHETERIZATION	0	18,864	18,329	37,193	159	59.00
60.00	LABORATORY	0	58,862	281,734	340,596	1,089	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	10,255	31,814	42,069	206	65.00
66.00	PHYSICAL THERAPY	0	51,289	19,022	70,311	372	66.00
67.00	OCCUPATIONAL THERAPY	0	0	1,566	1,566	67	67.00
68.00	SPEECH PATHOLOGY	0	16,740	16,086	32,826	167	68.00
69.00	ELECTROCARDIOLOGY	0	38,053	114,180	152,233	409	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	30,473	27,961	58,434	84	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	ASC (NON-DISTINCT PART)	0	71,839	113,039	184,878	368	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	18,048	3,111	21,159	112	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	94,546	9,737	104,283	93	88.00
88.01	RURAL HEALTH CLINIC II	0	46,072	1,330	47,402	97	88.01
88.02	RURAL HEALTH CLINIC III	0	18,791	1,597	20,388	117	88.02
91.00	EMERGENCY	0	59,632	49,346	108,978	1,758	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	21,745	3,153	24,898	672	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	15,532	423	15,955	306	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,969,932	8,013,336	9,983,268	17,076	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	589,498	135,613	725,111	5,920	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	WELLNESS	0	0	1,634	1,634	27	194.01
194.02	LIFELINE	0	1,593	0	1,593	9	194.02
194.03	OCCUPATIONAL HEALTH	0	19,322	6,366	25,688	117	194.03
194.05	MISC. NONREIMBURSABLE	0	122,052	144,163	266,215	185	194.05
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,702,397	8,301,112	11,003,509	23,334	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189		Period: From 07/01/2010 To 06/30/2011		Worksheet B Part II Date/Time Prepared: 12/13/2011 3:00 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	1,944,492					5.00
7.00	OPERATION OF PLANT	63,958	373,230				7.00
8.00	LAUNDRY & LINEN SERVICE	5,955	1,202	14,213			8.00
9.00	HOUSEKEEPING	25,058	7,235	0	82,417		9.00
10.00	DIETARY	16,913	7,431	87	0	93,466	10.00
11.00	CAFETERIA	11,003	4,497	0	4,382	0	11.00
13.00	NURSING ADMINISTRATION	25,311	1,604	0	1,095	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	18,892	7,221	418	792	0	14.00
15.00	PHARMACY	23,970	2,983	0	792	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	33,158	4,540	0	746	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	145,742	37,912	4,719	1,329	73,796	30.00
32.00	CORONARY CARE UNIT	24,379	5,017	469	4,009	3,637	32.00
40.00	SUBPROVIDER - IPF	25,899	9,868	266	0	12,892	40.00
43.00	NURSERY	6,900	698	144	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	72,969	27,348	1,830	10,559	1,776	50.00
51.00	RECOVERY ROOM	14,664	1,781	373	2,168	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	11,630	1,593	291	0	0	52.00
53.00	ANESTHESIOLOGY	24,762	731	0	559	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	51,877	15,323	1,469	1,841	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	25,377	7,745	160	2,424	0	55.00
56.00	RADIOISOTOPE	63,226	2,205	1	653	0	56.00
57.00	CT SCAN	24,424	1,727	0	489	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	16,464	2,313	0	816	0	58.00
59.00	CARDIAC CATHETERIZATION	14,336	3,217	76	0	0	59.00
60.00	LABORATORY	142,483	10,039	2	3,193	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	17,768	1,749	0	676	0	65.00
66.00	PHYSICAL THERAPY	29,715	8,747	235	3,636	0	66.00
67.00	OCCUPATIONAL THERAPY	5,205	0	0	140	0	67.00
68.00	SPEECH PATHOLOGY	4,529	2,855	0	233	0	68.00
69.00	ELECTROCARDIOLOGY	20,379	6,490	141	1,072	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	8,810	5,197	31	1,002	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,986	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	46,389	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	104,926	0	0	0	0	73.00
75.00	ASC (NON-DISTINCT PART)	40,642	12,252	989	7,762	0	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,275	3,078	0	746	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	9,722	16,124	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	9,237	7,857	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	9,938	3,205	0	0	0	88.02
91.00	EMERGENCY	79,216	10,170	2,499	13,402	1,365	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	55,558	3,708	0	513	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	30,936	2,649	0	373	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,420,581	248,311	14,200	65,402	93,466	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	484,365	100,537	0	12,237	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	WELLNESS	3,031	0	0	140	0	194.01
194.02	LIFELINE	2,504	272	0	0	0	194.02
194.03	OCCUPATIONAL HEALTH	8,802	3,295	13	862	0	194.03
194.05	MISC. NONREIMBURSABLE	25,209	20,815	0	3,776	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,944,492	373,230	14,213	82,417	93,466	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part II Date/Time Prepared: 12/13/2011 3:00 pm
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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						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00	77,725					11.00
13.00	1,714	47,222				13.00
14.00	1,028	0	208,377			14.00
15.00	1,371	0	0	86,148		15.00
16.00	3,342	0	0	0	84,905	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	13,366	21,489	0	0	5,293	30.00
32.00	1,714	2,746	0	0	676	32.00
40.00	1,885	2,609	0	0	860	40.00
43.00	600	1,067	0	0	297	43.00
44.00	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	4,628	7,499	0	0	4,695	50.00
51.00	943	1,594	0	0	959	51.00
52.00	857	1,522	0	0	950	52.00
53.00	1,543	459	0	0	1,872	53.00
54.00	2,485	0	0	0	4,434	54.00
55.00	1,114	0	0	0	1,575	55.00
56.00	1,028	0	0	0	3,469	56.00
57.00	514	0	0	0	7,705	57.00
58.00	343	0	0	0	3,047	58.00
59.00	514	0	0	0	342	59.00
60.00	7,370	0	0	0	12,042	60.00
60.01	0	0	0	0	0	60.01
65.00	1,285	0	0	0	1,664	65.00
66.00	1,285	0	0	0	1,580	66.00
67.00	343	0	0	0	229	67.00
68.00	857	0	0	0	375	68.00
69.00	1,457	0	0	0	1,089	69.00
70.00	686	0	0	0	1,116	70.00
71.00	0	0	93,770	0	4,130	71.00
72.00	0	0	114,607	0	2,767	72.00
73.00	0	0	0	86,148	10,585	73.00
75.00	2,314	0	0	0	5,152	75.00
76.00	857	0	0	0	47	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	0	0	0	0	117	88.00
88.01	0	0	0	0	86	88.01
88.02	0	0	0	0	207	88.02
91.00	5,656	8,237	0	0	7,545	91.00
92.00						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	1,628	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	1,457	0	0	0	0	116.00
118.00	64,184	47,222	208,377	86,148	84,905	118.00
NONREIMBURSABLE COST CENTERS						
192.00	11,912	0	0	0	0	192.00
194.00	686	0	0	0	0	194.00
194.01	257	0	0	0	0	194.01
194.02	0	0	0	0	0	194.02
194.03	686	0	0	0	0	194.03
194.05	0	0	0	0	0	194.05
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	77,725	47,222	208,377	86,148	84,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part II Date/Time Prepared: 12/13/2011 3:00 pm
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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	786,492	0	786,492	30.00
32.00 CORONARY CARE UNIT	124,532	0	124,532	32.00
40.00 SUBPROVIDER - IPF	126,176	0	126,176	40.00
43.00 NURSERY	23,266	0	23,266	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	879,465	0	879,465	50.00
51.00 RECOVERY ROOM	67,673	0	67,673	51.00
52.00 DELIVERY ROOM & LABOR ROOM	63,310	0	63,310	52.00
53.00 ANESTHESIOLOGY	107,225	0	107,225	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,085,211	0	1,085,211	54.00
55.00 RADIOLOGY-THERAPEUTIC	387,556	0	387,556	55.00
56.00 RADIOISOTOPE	2,296,048	0	2,296,048	56.00
57.00 CT SCAN	507,716	0	507,716	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	372,679	0	372,679	58.00
59.00 CARDIAC CATHETERIZATION	55,837	0	55,837	59.00
60.00 LABORATORY	516,814	0	516,814	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	65,417	0	65,417	65.00
66.00 PHYSICAL THERAPY	115,881	0	115,881	66.00
67.00 OCCUPATIONAL THERAPY	7,550	0	7,550	67.00
68.00 SPEECH PATHOLOGY	41,842	0	41,842	68.00
69.00 ELECTROCARDIOLOGY	183,270	0	183,270	69.00
70.00 ELECTROENCEPHALOGRAPHY	75,360	0	75,360	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	147,886	0	147,886	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	163,763	0	163,763	72.00
73.00 DRUGS CHARGED TO PATIENTS	201,659	0	201,659	73.00
75.00 ASC (NON-DISTINCT PART)	254,357	0	254,357	75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	34,274	0	34,274	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	130,339	0	130,339	88.00
88.01 RURAL HEALTH CLINIC II	64,679	0	64,679	88.01
88.02 RURAL HEALTH CLINIC III	33,855	0	33,855	88.02
91.00 EMERGENCY	238,826	0	238,826	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 HOME HEALTH AGENCY	86,977	0	86,977	101.00
SPECIAL PURPOSE COST CENTERS				
116.00 HOSPICE	51,676	0	51,676	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9,297,611	0	9,297,611	118.00
NONREIMBURSABLE COST CENTERS				
192.00 PHYSICIANS' PRIVATE OFFICES	1,340,082	0	1,340,082	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	686	0	686	194.00
194.01 WELLNESS	5,089	0	5,089	194.01
194.02 LIFELINE	4,378	0	4,378	194.02
194.03 OCCUPATIONAL HEALTH	39,463	0	39,463	194.03
194.05 MISC. NONREIMBURSABLE	316,200	0	316,200	194.05
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)	11,003,509	0	11,003,509	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1

Date/Time Prepared:
12/13/2011 3:00 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	407,135					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		8,963,489				2.00
4.00	EMPLOYEE BENEFITS	3,113	2,884	85,351,482			4.00
5.00	ADMINISTRATIVE & GENERAL	43,651	1,783,975	9,555,087	-25,066,104	129,229,055	5.00
7.00	OPERATION OF PLANT	30,665	113,891	935,738	0	4,250,567	7.00
8.00	LAUNDRY & LINEN SERVICE	1,062	0	27,290	0	395,752	8.00
9.00	HOUSEKEEPING	6,391	8,008	1,052,164	0	1,665,296	9.00
10.00	DIETARY	6,564	27,340	533,465	0	1,124,005	10.00
11.00	CAFETERIA	3,973	33,783	675,933	0	731,247	11.00
13.00	NURSING ADMINISTRATION	1,417	8,371	1,249,872	0	1,682,153	13.00
14.00	CENTRAL SERVICES & SUPPLY	6,379	148,560	376,126	0	1,255,542	14.00
15.00	PHARMACY	2,635	42,375	1,091,034	0	1,592,982	15.00
16.00	MEDICAL RECORDS & LIBRARY	4,011	17,407	1,374,134	0	2,203,638	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	33,491	279,273	6,996,155	0	9,685,810	30.00
32.00	CORONARY CARE UNIT	4,432	56,320	1,131,501	0	1,620,210	32.00
40.00	SUBPROVIDER - IPF	8,717	14,540	2,090,186	0	1,721,176	40.00
43.00	NURSERY	617	10,115	356,969	0	458,544	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	24,159	633,873	2,824,476	0	4,849,383	50.00
51.00	RECOVERY ROOM	1,573	37,326	665,455	0	974,519	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,407	39,931	541,723	0	772,913	52.00
53.00	ANESTHESIOLOGY	646	77,580	4,265,338	0	1,645,666	53.00
54.00	RADIOLOGY-DIAGNOSTIC	13,536	990,759	1,433,704	0	3,447,664	54.00
55.00	RADIOLOGY-THERAPEUTIC	6,842	327,510	1,608,553	0	1,686,518	55.00
56.00	RADIOISOTOPE	1,948	2,388,829	879,323	0	4,201,909	56.00
57.00	CT SCAN	1,526	499,545	357,499	0	1,623,212	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	2,043	362,876	270,034	0	1,094,183	58.00
59.00	CARDIAC CATHETERIZATION	2,842	19,791	583,550	0	952,777	59.00
60.00	LABORATORY	8,868	304,215	3,989,005	0	9,469,171	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	1,545	34,353	753,349	0	1,180,818	65.00
66.00	PHYSICAL THERAPY	7,727	20,540	1,361,686	0	1,974,788	66.00
67.00	OCCUPATIONAL THERAPY	0	1,691	244,079	0	345,937	67.00
68.00	SPEECH PATHOLOGY	2,522	17,370	613,256	0	300,977	68.00
69.00	ELECTROCARDIOLOGY	5,733	123,291	1,499,855	0	1,354,373	69.00
70.00	ELECTROENCEPHALOGRAPHY	4,591	30,192	307,866	0	585,485	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,321,970	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	3,082,957	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,973,198	73.00
75.00	ASC (NON-DISTINCT PART)	10,823	122,059	1,348,373	0	2,700,983	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	3,359	410,697	0	549,925	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	14,244	10,514	342,346	0	646,086	88.00
88.01	RURAL HEALTH CLINIC II	6,941	1,436	355,327	0	613,903	88.01
88.02	RURAL HEALTH CLINIC III	2,831	1,724	428,882	0	660,455	88.02
91.00	EMERGENCY	8,984	53,283	6,438,133	0	5,264,583	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	3,276	3,405	2,463,025	0	3,692,310	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	2,340	457	1,119,500	0	2,055,945	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	296,784	8,652,751	62,550,688	-25,066,104	94,409,530	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	88,812	146,434	21,563,018	0	32,191,363	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	WELLNESS	0	1,764	98,703	0	201,446	194.01
194.02	LIFELINE	240	0	34,419	0	166,379	194.02
194.03	OCCUPATIONAL HEALTH	2,911	6,874	428,529	0	584,962	194.03
194.05	MISC. NONREIMBURSABLE	18,388	155,666	676,125	0	1,675,375	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,702,397	8,301,112	18,396,483		25,066,104	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.637594	0.926103	0.215538		0.193966	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			23,334		1,944,492	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000273		0.015047	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1

Date/Time Prepared:
12/13/2011 3:00 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
	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	329,706					7.00
8.00 LAUNDRY & LINEN SERVICE	1,062	702,295				8.00
9.00 HOUSEKEEPING	6,391	0	3,536			9.00
10.00 DIETARY	6,564	4,283	0	123,017		10.00
11.00 CAFETERIA	3,973	0	188	0	907	11.00
13.00 NURSING ADMINISTRATION	1,417	0	47	0	20	13.00
14.00 CENTRAL SERVICES & SUPPLY	6,379	20,648	34	0	0	14.00
15.00 PHARMACY	2,635	0	34	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	4,011	0	32	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	33,491	233,315	57	97,129	156	30.00
32.00 CORONARY CARE UNIT	4,432	23,151	172	4,787	20	32.00
40.00 SUBPROVIDER - IPF	8,717	13,152	0	16,968	22	40.00
43.00 NURSERY	617	7,129	0	0	7	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	24,159	90,423	453	2,337	54	50.00
51.00 RECOVERY ROOM	1,573	18,426	93	0	11	51.00
52.00 DELIVERY ROOM & LABOR ROOM	1,407	14,359	0	0	10	52.00
53.00 ANESTHESIOLOGY	646	0	24	0	18	53.00
54.00 RADIOLOGY-DIAGNOSTIC	13,536	72,608	79	0	29	54.00
55.00 RADIOLOGY-THERAPEUTIC	6,842	7,891	104	0	13	55.00
56.00 RADIOISOTOPE	1,948	49	28	0	12	56.00
57.00 CT SCAN	1,526	0	21	0	6	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	2,043	0	35	0	4	58.00
59.00 CARDIAC CATHETERIZATION	2,842	3,735	0	0	6	59.00
60.00 LABORATORY	8,868	89	137	0	86	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	1,545	0	29	0	15	65.00
66.00 PHYSICAL THERAPY	7,727	11,600	156	0	15	66.00
67.00 OCCUPATIONAL THERAPY	0	0	6	0	4	67.00
68.00 SPEECH PATHOLOGY	2,522	0	10	0	10	68.00
69.00 ELECTROCARDIOLOGY	5,733	6,968	46	0	17	69.00
70.00 ELECTROENCEPHALOGRAPHY	4,591	1,529	43	0	8	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 ASC (NON-DISTINCT PART)	10,823	48,857	333	0	27	75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	0	32	0	10	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	14,244	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	6,941	0	0	0	0	88.01
88.02 RURAL HEALTH CLINIC III	2,831	0	0	0	0	88.02
91.00 EMERGENCY	8,984	123,459	575	1,796	66	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	3,276	0	22	0	19	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	2,340	0	16	0	17	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	219,355	701,671	2,806	123,017	749	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	88,812	0	525	0	139	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	8	194.00
194.01 WELLNESS	0	0	6	0	3	194.01
194.02 LIFELINE	240	0	0	0	0	194.02
194.03 OCCUPATIONAL HEALTH	2,911	624	37	0	8	194.03
194.05 MISC. NONREIMBURSABLE	18,388	0	162	0	0	194.05
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	5,075,032	488,861	2,086,681	1,446,042	1,045,182	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	15.392598	0.696091	590.124717	11.754814	1,152.350606	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	373,230	14,213	82,417	93,466	77,725	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	1.132009	0.020238	23.307975	0.759781	85.694598	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet B-1

Date/Time Prepared:
12/13/2011 3:00 pm

Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS) 13.00	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14.00	PHARMACY (COSTED REQUIS.) 15.00	MEDICAL RECORDS & LIBRARY (GROSS CHARGES) 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	626,063				13.00
14.00 CENTRAL SERVICES & SUPPLY	0	100			14.00
15.00 PHARMACY	0	0	100		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	363,189,529	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	284,905	0	0	22,618,636	30.00
32.00 CORONARY CARE UNIT	36,402	0	0	2,889,140	32.00
40.00 SUBPROVIDER - IPF	34,584	0	0	3,677,071	40.00
43.00 NURSERY	14,144	0	0	1,268,078	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	99,426	0	0	20,064,882	50.00
51.00 RECOVERY ROOM	21,132	0	0	4,099,427	51.00
52.00 DELIVERY ROOM & LABOR ROOM	20,176	0	0	4,058,788	52.00
53.00 ANESTHESIOLOGY	6,084	0	0	7,999,203	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	18,947,109	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	6,728,876	55.00
56.00 RADIOISOTOPE	0	0	0	14,823,181	56.00
57.00 CT SCAN	0	0	0	32,925,765	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	13,020,419	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	1,461,768	59.00
60.00 LABORATORY	0	0	0	51,814,225	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	7,111,865	65.00
66.00 PHYSICAL THERAPY	0	0	0	6,753,343	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	979,877	67.00
68.00 SPEECH PATHOLOGY	0	0	0	1,601,299	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	4,655,206	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	4,768,110	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45	0	17,649,908	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	55	0	11,823,141	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	100	45,237,058	73.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	22,015,672	75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	199,731	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0	501,953	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	366,283	88.01
88.02 RURAL HEALTH CLINIC III	0	0	0	884,913	88.02
91.00 EMERGENCY	109,210	0	0	32,244,602	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00 HOSPICE	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	626,063	100	100	363,189,529	118.00
NONREIMBURSABLE COST CENTERS					
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 WELLNESS	0	0	0	0	194.01
194.02 LIFELINE	0	0	0	0	194.02
194.03 OCCUPATIONAL HEALTH	0	0	0	0	194.03
194.05 MISC. NONREIMBURSABLE	0	0	0	0	194.05
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2,081,027	1,645,528	1,981,027	2,756,635	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	3.323990	16,455.280000	19,810.270000	0.007590	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	47,222	208,377	86,148	84,905	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.075427	2,083.770000	861.480000	0.000234	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/13/2011 3:00 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	14,716,281	14,716,281	38,098	14,754,379	30.00
32.00	CORONARY CARE UNIT	2,342,558	2,342,558	0	2,342,558	32.00
40.00	SUBPROVIDER - IPF	2,566,032	2,566,032	0	2,566,032	40.00
43.00	NURSERY	626,651	626,651	0	626,651	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,064,618	7,064,618	0	7,064,618	50.00
51.00	RECOVERY ROOM	1,369,498	1,369,498	0	1,369,498	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,063,879	1,063,879	0	1,063,879	52.00
53.00	ANESTHESIOLOGY	2,090,655	2,090,655	118,714	2,209,369	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,599,137	4,599,137	0	4,599,137	54.00
55.00	RADIOLOGY-THERAPEUTIC	2,251,880	2,251,880	0	2,251,880	55.00
56.00	RADIOISOTOPE	5,189,814	5,189,814	0	5,189,814	56.00
57.00	CT SCAN	2,230,763	2,230,763	0	2,230,763	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	1,461,952	1,461,952	0	1,461,952	58.00
59.00	CARDIAC CATHETERIZATION	1,201,938	1,201,938	0	1,201,938	59.00
60.00	LABORATORY	12,015,676	12,015,676	31,304	12,046,980	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	1,522,017	1,522,017	0	1,522,017	65.00
66.00	PHYSICAL THERAPY	2,645,446	2,645,446	0	2,645,446	66.00
67.00	OCCUPATIONAL THERAPY	428,624	428,624	0	428,624	67.00
68.00	SPEECH PATHOLOGY	427,755	427,755	0	427,755	68.00
69.00	ELECTROCARDIOLOGY	1,792,240	1,792,240	0	1,792,240	69.00
70.00	ELECTROENCEPHALOGRAPHY	841,564	841,564	0	841,564	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,840,770	4,840,770	0	4,840,770	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,675,724	4,675,724	0	4,675,724	72.00
73.00	DRUGS CHARGED TO PATIENTS	10,650,137	10,650,137	0	10,650,137	73.00
75.00	ASC (NON-DISTINCT PART)	3,820,209	3,820,209	0	3,820,209	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	730,368	730,368	0	730,368	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	994,467	994,467	0	994,467	88.00
88.01	RURAL HEALTH CLINIC II	842,599	842,599	0	842,599	88.01
88.02	RURAL HEALTH CLINIC III	838,853	838,853	0	838,853	88.02
91.00	EMERGENCY	7,554,199	7,554,199	84,564	7,638,763	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,974,064	1,974,064	0	1,974,064	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	4,493,797	4,493,797	0	4,493,797	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	2,519,779	2,519,779	0	2,519,779	116.00
200.00	Subtotal (see instructions)	112,383,944	112,383,944	272,680	112,656,624	200.00
201.00	Less Observation Beds	1,974,064	1,974,064	0	1,974,064	201.00
202.00	Total (see instructions)	110,409,880	110,409,880	272,680	110,682,560	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/13/2011 3:00 pm	
			Title XVIIII	Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	18,657,086		18,657,086		30.00
32.00	CORONARY CARE UNIT	2,889,140		2,889,140		32.00
40.00	SUBPROVIDER - IPF	3,677,071		3,677,071		40.00
43.00	NURSERY	1,268,078		1,268,078		43.00
44.00	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,850,439	11,214,443	20,064,882	0.352089	50.00
51.00	RECOVERY ROOM	1,446,394	2,653,033	4,099,427	0.334071	51.00
52.00	DELIVERY ROOM & LABOR ROOM	3,766,303	292,485	4,058,788	0.262117	52.00
53.00	ANESTHESIOLOGY	2,542,085	5,457,118	7,999,203	0.261358	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,383,232	15,563,877	18,947,109	0.242736	54.00
55.00	RADIOLOGY-THERAPEUTIC	139,037	6,589,839	6,728,876	0.334659	55.00
56.00	RADIOISOTOPE	2,445,637	12,377,544	14,823,181	0.350115	56.00
57.00	CT SCAN	6,652,227	26,273,538	32,925,765	0.067751	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	963,575	12,056,844	13,020,419	0.112281	58.00
59.00	CARDIAC CATHETERIZATION	486,430	975,338	1,461,768	0.822249	59.00
60.00	LABORATORY	11,059,974	40,754,251	51,814,225	0.231899	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	RESPIRATORY THERAPY	5,857,305	1,254,560	7,111,865	0.214011	65.00
66.00	PHYSICAL THERAPY	758,199	5,995,144	6,753,343	0.391724	66.00
67.00	OCCUPATIONAL THERAPY	184,683	795,194	979,877	0.437426	67.00
68.00	SPEECH PATHOLOGY	153,411	1,447,888	1,601,299	0.267130	68.00
69.00	ELECTROCARDIOLOGY	1,142,599	3,512,607	4,655,206	0.384997	69.00
70.00	ELECTROENCEPHALOGRAPHY	38,591	4,729,519	4,768,110	0.176498	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,421,356	11,228,552	17,649,908	0.274266	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,942,749	2,880,392	11,823,141	0.395472	72.00
73.00	DRUGS CHARGED TO PATIENTS	19,175,555	26,061,503	45,237,058	0.235429	73.00
75.00	ASC (NON-DISTINCT PART)	209,196	21,806,476	22,015,672	0.173522	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	199,731	199,731	3.656758	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	501,953	501,953		88.00
88.01	RURAL HEALTH CLINIC II	0	366,283	366,283		88.01
88.02	RURAL HEALTH CLINIC III	0	884,913	884,913		88.02
91.00	EMERGENCY	7,212,530	25,032,072	32,244,602	0.234278	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,961,550	3,961,550	0.498306	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0		116.00
200.00	Subtotal (see instructions)	118,322,882	244,866,647	363,189,529		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	118,322,882	244,866,647	363,189,529		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/13/2011 3:00 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
32.00	CORONARY CARE UNIT			32.00
40.00	SUBPROVIDER - IPF			40.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.352089		50.00
51.00	RECOVERY ROOM	0.334071		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.262117		52.00
53.00	ANESTHESIOLOGY	0.276199		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.242736		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.334659		55.00
56.00	RADIOISOTOPE	0.350115		56.00
57.00	CT SCAN	0.067751		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.112281		58.00
59.00	CARDIAC CATHETERIZATION	0.822249		59.00
60.00	LABORATORY	0.232503		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
65.00	RESPIRATORY THERAPY	0.214011		65.00
66.00	PHYSICAL THERAPY	0.391724		66.00
67.00	OCCUPATIONAL THERAPY	0.437426		67.00
68.00	SPEECH PATHOLOGY	0.267130		68.00
69.00	ELECTROCARDIOLOGY	0.384997		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.176498		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274266		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.395472		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.235429		73.00
75.00	ASC (NON-DISTINCT PART)	0.173522		75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.656758		76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC			88.00
88.01	RURAL HEALTH CLINIC II			88.01
88.02	RURAL HEALTH CLINIC III			88.02
91.00	EMERGENCY	0.236901		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.498306		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description	Title XVIII			Hospital	PPS		
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	786,492	0	786,492	22,101	35.59	30.00
32.00	CORONARY CARE UNIT	124,532	0	124,532	1,849	67.35	32.00
40.00	SUBPROVIDER - IPF	126,176	0	126,176	3,672	34.36	40.00
43.00	NURSERY	23,266		23,266	1,170	19.89	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (Lines 30-199)	1,060,466		1,060,466	28,792		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140189		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 12/13/2011 3:00 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII	Hospital	PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	11,484	408,716				30.00
32.00	CORONARY CARE UNIT	1,063	71,593				32.00
40.00	SUBPROVIDER - IPF	1,252	43,019				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (Lines 30-199)	13,799	523,328				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		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	879,465	20,064,882	0.043831	4,402,339	192,959	50.00
51.00	RECOVERY ROOM	67,673	4,099,427	0.016508	532,972	8,798	51.00
52.00	DELIVERY ROOM & LABOR ROOM	63,310	4,058,788	0.015598	14,848	232	52.00
53.00	ANESTHESIOLOGY	107,225	7,999,203	0.013404	1,089,008	14,597	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,085,211	18,947,109	0.057276	2,342,655	134,178	54.00
55.00	RADIOLOGY-THERAPEUTIC	387,556	6,728,876	0.057596	63,043	3,631	55.00
56.00	RADIOISOTOPE	2,296,048	14,823,181	0.154896	1,436,908	222,571	56.00
57.00	CT SCAN	507,716	32,925,765	0.015420	4,035,155	62,222	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	372,679	13,020,419	0.028623	629,123	18,007	58.00
59.00	CARDIAC CATHETERIZATION	55,837	1,461,768	0.038198	283,612	10,833	59.00
60.00	LABORATORY	516,814	51,814,225	0.009974	6,408,772	63,921	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	65,417	7,111,865	0.009198	3,530,249	32,471	65.00
66.00	PHYSICAL THERAPY	115,881	6,753,343	0.017159	499,708	8,574	66.00
67.00	OCCUPATIONAL THERAPY	7,550	979,877	0.007705	125,437	966	67.00
68.00	SPEECH PATHOLOGY	41,842	1,601,299	0.026130	72,714	1,900	68.00
69.00	ELECTROCARDIOLOGY	183,270	4,655,206	0.039369	626,279	24,656	69.00
70.00	ELECTROENCEPHALOGRAPHY	75,360	4,768,110	0.015805	23,091	365	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,886	17,649,908	0.008379	3,100,589	25,980	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	163,763	11,823,141	0.013851	5,251,200	72,734	72.00
73.00	DRUGS CHARGED TO PATIENTS	201,659	45,237,058	0.004458	10,709,704	47,744	73.00
75.00	ASC (NON-DISTINCT PART)	254,357	22,015,672	0.011553	0	0	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	34,274	199,731	0.171601	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	130,339	501,953	0.259664	0	0	88.00
88.01	RURAL HEALTH CLINIC II	64,679	366,283	0.176582	0	0	88.01
88.02	RURAL HEALTH CLINIC III	33,855	884,913	0.038258	0	0	88.02
91.00	EMERGENCY	238,826	32,244,602	0.007407	2,730,319	20,223	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	105,229	3,961,550	0.026563	0	0	92.00
200.00	Total (lines 50-199)	8,203,721	336,698,154		47,907,725	967,562	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140189		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 12/13/2011 3:00 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Title XVIII		Hospital	PPS
			Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	22,101	0.00	11,484	0	30.00
32.00	CORONARY CARE UNIT	1,849	0.00	1,063	0	32.00
40.00	SUBPROVIDER - IPF	3,672	0.00	1,252	0	40.00
43.00	NURSERY	1,170	0.00	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00	Total (Lines 30-199)	28,792		13,799	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00 OPERATING ROOM	0	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	0	75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	0	0	0	88.01
88.02 RURAL HEALTH CLINIC III	0	0	0	0	0	0	0	88.02
91.00 EMERGENCY	0	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
200.00 Total (Lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description		Title XVIII			Hospital		PPS
		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	20,064,882	0.000000	0.000000	4,402,339	50.00
51.00	RECOVERY ROOM	0	4,099,427	0.000000	0.000000	532,972	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	4,058,788	0.000000	0.000000	14,848	52.00
53.00	ANESTHESIOLOGY	0	7,999,203	0.000000	0.000000	1,089,008	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	18,947,109	0.000000	0.000000	2,342,655	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	6,728,876	0.000000	0.000000	63,043	55.00
56.00	RADIOISOTOPE	0	14,823,181	0.000000	0.000000	1,436,908	56.00
57.00	CT SCAN	0	32,925,765	0.000000	0.000000	4,035,155	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	13,020,419	0.000000	0.000000	629,123	58.00
59.00	CARDIAC CATHETERIZATION	0	1,461,768	0.000000	0.000000	283,612	59.00
60.00	LABORATORY	0	51,814,225	0.000000	0.000000	6,408,772	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0	7,111,865	0.000000	0.000000	3,530,249	65.00
66.00	PHYSICAL THERAPY	0	6,753,343	0.000000	0.000000	499,708	66.00
67.00	OCCUPATIONAL THERAPY	0	979,877	0.000000	0.000000	125,437	67.00
68.00	SPEECH PATHOLOGY	0	1,601,299	0.000000	0.000000	72,714	68.00
69.00	ELECTROCARDIOLOGY	0	4,655,206	0.000000	0.000000	626,279	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	4,768,110	0.000000	0.000000	23,091	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,649,908	0.000000	0.000000	3,100,589	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	11,823,141	0.000000	0.000000	5,251,200	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	45,237,058	0.000000	0.000000	10,709,704	73.00
75.00	ASC (NON-DISTINCT PART)	0	22,015,672	0.000000	0.000000	0	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	199,731	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	501,953	0.000000	0.000000	0	88.00
88.01	RURAL HEALTH CLINIC II	0	366,283	0.000000	0.000000	0	88.01
88.02	RURAL HEALTH CLINIC III	0	884,913	0.000000	0.000000	0	88.02
91.00	EMERGENCY	0	32,244,602	0.000000	0.000000	2,730,319	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,961,550	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	0	336,698,154			47,907,725	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/13/2011 3:00 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	8,907,011	0	50.00
51.00	RECOVERY ROOM	0	965,037	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	3,198	0	52.00
53.00	ANESTHESIOLOGY	0	1,549,403	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	4,392,652	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	2,526,668	0	55.00
56.00	RADIOISOTOPE	0	3,009,723	0	56.00
57.00	CT SCAN	0	7,789,323	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	3,376,048	0	58.00
59.00	CARDIAC CATHETERIZATION	0	327,154	0	59.00
60.00	LABORATORY	0	1,244,948	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	487,628	0	65.00
66.00	PHYSICAL THERAPY	0	85,688	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	153,612	0	68.00
69.00	ELECTROCARDIOLOGY	0	1,517,625	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	1,362,299	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,908,202	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,291,076	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	11,845,661	0	73.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III	0	0	0	88.02
91.00	EMERGENCY	0	6,242,320	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,748,661	0	92.00
200.00	Total (Lines 50-199)	0	60,733,937	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/13/2011 3:00 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	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	0.352089	8,907,011	698	0	50.00
51.00	RECOVERY ROOM	0.334071	965,037	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.262117	3,198	0	0	52.00
53.00	ANESTHESIOLOGY	0.261358	1,549,403	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.242736	4,392,652	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.334659	2,526,668	-13,255	0	55.00
56.00	RADIOISOTOPE	0.350115	3,009,723	0	0	56.00
57.00	CT SCAN	0.067751	7,789,323	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.112281	3,376,048	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.822249	327,154	0	0	59.00
60.00	LABORATORY	0.231899	1,244,948	-2,036	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0.214011	487,628	0	0	65.00
66.00	PHYSICAL THERAPY	0.391724	85,688	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.437426	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.267130	153,612	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.384997	1,517,625	-952	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.176498	1,362,299	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274266	1,908,202	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.395472	1,291,076	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.235429	11,845,661	-19,753	32,327	73.00
75.00	ASC (NON-DISTINCT PART)	0.173522	0	0	0	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.656758	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
88.01	RURAL HEALTH CLINIC II	0.000000				88.01
88.02	RURAL HEALTH CLINIC III	0.000000				88.02
91.00	EMERGENCY	0.234278	6,242,320	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.498306	1,748,661	0	0	92.00
200.00	Subtotal (see instructions)		60,733,937	-35,298	32,327	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		60,733,937	-35,298	32,327	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/13/2011 3:00 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	3,136,061	246	0		50.00
51.00 RECOVERY ROOM	322,391	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	838	0	0		52.00
53.00 ANESTHESIOLOGY	404,949	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,066,255	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	845,572	-4,436	0		55.00
56.00 RADIOISOTOPE	1,053,749	0	0		56.00
57.00 CT SCAN	527,734	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	379,066	0	0		58.00
59.00 CARDIAC CATHETERIZATION	269,002	0	0		59.00
60.00 LABORATORY	288,702	-472	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	104,358	0	0		65.00
66.00 PHYSICAL THERAPY	33,566	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	41,034	0	0		68.00
69.00 ELECTROCARDIOLOGY	584,281	-367	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	240,443	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	523,355	0	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	510,584	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	2,788,812	-4,650	7,611		73.00
75.00 ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
88.01 RURAL HEALTH CLINIC II	0	0	0		88.01
88.02 RURAL HEALTH CLINIC III	0	0	0		88.02
91.00 EMERGENCY	1,462,438	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	871,368	0	0		92.00
200.00 Subtotal (see instructions)	15,454,558	-9,679	7,611		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	15,454,558	-9,679	7,611		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 140189 Component CCN: 14S189		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part II Date/Time Prepared: 12/13/2011 3:00 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	879,465	20,064,882	0.043831	3,467	152	50.00	
51.00	RECOVERY ROOM	67,673	4,099,427	0.016508	0	0	51.00	
52.00	DELIVERY ROOM & LABOR ROOM	63,310	4,058,788	0.015598	0	0	52.00	
53.00	ANESTHESIOLOGY	107,225	7,999,203	0.013404	0	0	53.00	
54.00	RADIOLOGY-DIAGNOSTIC	1,085,211	18,947,109	0.057276	16,638	953	54.00	
55.00	RADIOLOGY-THERAPEUTIC	387,556	6,728,876	0.057596	0	0	55.00	
56.00	RADIOISOTOPE	2,296,048	14,823,181	0.154896	6,051	937	56.00	
57.00	CT SCAN	507,716	32,925,765	0.015420	42,730	659	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)	372,679	13,020,419	0.028623	13,123	376	58.00	
59.00	CARDIAC CATHETERIZATION	55,837	1,461,768	0.038198	0	0	59.00	
60.00	LABORATORY	516,814	51,814,225	0.009974	283,727	2,830	60.00	
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01	
65.00	RESPIRATORY THERAPY	65,417	7,111,865	0.009198	101,621	935	65.00	
66.00	PHYSICAL THERAPY	115,881	6,753,343	0.017159	4,684	80	66.00	
67.00	OCCUPATIONAL THERAPY	7,550	979,877	0.007705	1,752	13	67.00	
68.00	SPEECH PATHOLOGY	41,842	1,601,299	0.026130	1,108	29	68.00	
69.00	ELECTROCARDIOLOGY	183,270	4,655,206	0.039369	5,218	205	69.00	
70.00	ELECTROENCEPHALOGRAPHY	75,360	4,768,110	0.015805	680	11	70.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,886	17,649,908	0.008379	2,635	22	71.00	
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	163,763	11,823,141	0.013851	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS	201,659	45,237,058	0.004458	426,256	1,900	73.00	
75.00	ASC (NON-DISTINCT PART)	254,357	22,015,672	0.011553	0	0	75.00	
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	34,274	199,731	0.171601	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	130,339	501,953	0.259664	0	0	88.00	
88.01	RURAL HEALTH CLINIC II	64,679	366,283	0.176582	0	0	88.01	
88.02	RURAL HEALTH CLINIC III	33,855	884,913	0.038258	0	0	88.02	
91.00	EMERGENCY	238,826	32,244,602	0.007407	198,755	1,472	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	105,229	3,961,550	0.026563	0	0	92.00	
200.00	Total (Lines 50-199)	8,203,721	336,698,154		1,108,445	10,574	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/13/2011 3:00 pm
	Component CCN: 14S189	Title XVIII	Subprovider - IPF PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02 RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
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: 140189 Component CCN: 14S189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/13/2011 3:00 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	20,064,882	0.000000	0.000000	3,467	50.00
51.00 RECOVERY ROOM	0	4,099,427	0.000000	0.000000	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	4,058,788	0.000000	0.000000	0	52.00
53.00 ANESTHESIOLOGY	0	7,999,203	0.000000	0.000000	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	18,947,109	0.000000	0.000000	16,638	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	6,728,876	0.000000	0.000000	0	55.00
56.00 RADIOISOTOPE	0	14,823,181	0.000000	0.000000	6,051	56.00
57.00 CT SCAN	0	32,925,765	0.000000	0.000000	42,730	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	13,020,419	0.000000	0.000000	13,123	58.00
59.00 CARDIAC CATHETERIZATION	0	1,461,768	0.000000	0.000000	0	59.00
60.00 LABORATORY	0	51,814,225	0.000000	0.000000	283,727	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 RESPIRATORY THERAPY	0	7,111,865	0.000000	0.000000	101,621	65.00
66.00 PHYSICAL THERAPY	0	6,753,343	0.000000	0.000000	4,684	66.00
67.00 OCCUPATIONAL THERAPY	0	979,877	0.000000	0.000000	1,752	67.00
68.00 SPEECH PATHOLOGY	0	1,601,299	0.000000	0.000000	1,108	68.00
69.00 ELECTROCARDIOLOGY	0	4,655,206	0.000000	0.000000	5,218	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	4,768,110	0.000000	0.000000	680	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,649,908	0.000000	0.000000	2,635	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	11,823,141	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	45,237,058	0.000000	0.000000	426,256	73.00
75.00 ASC (NON-DISTINCT PART)	0	22,015,672	0.000000	0.000000	0	75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	199,731	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	501,953	0.000000	0.000000	0	88.00
88.01 RURAL HEALTH CLINIC II	0	366,283	0.000000	0.000000	0	88.01
88.02 RURAL HEALTH CLINIC III	0	884,913	0.000000	0.000000	0	88.02
91.00 EMERGENCY	0	32,244,602	0.000000	0.000000	198,755	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,961,550	0.000000	0.000000	0	92.00
200.00 Total (Lines 50-199)	0	336,698,154			1,108,445	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/13/2011 3:00 pm
	Component CCN: 14S189	Title XVIII	Subprovider - IPF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	56.00
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
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	88.01
88.02 RURAL HEALTH CLINIC III	0	0	0	88.02
91.00 EMERGENCY	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (Lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 12/13/2011 3:00 pm
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,101	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,101	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		22,101	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		11,484	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,754,379	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		14,754,379	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		18,657,086	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		18,657,086	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.790819	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		844.17	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		14,754,379	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)		667.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,666,604	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)		7,666,604	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/13/2011 3:00 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	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)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT	2,342,558	1,849	1,266.93	1,063	1,346,747	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)					12,558,876	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					21,572,227	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)					480,309	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					967,562	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,447,871	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,124,356	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,957	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					667.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,974,064	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 12/13/2011 3:00 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	786,492	14,754,379	0.053306	1,974,064	105,229	90.00
91.00	Nursing School cost	0	14,754,379	0.000000	1,974,064	0	91.00
92.00	Allied health cost	0	14,754,379	0.000000	1,974,064	0	92.00
93.00	All other Medical Education	0	14,754,379	0.000000	1,974,064	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,672 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,672 2.00
3.00	Private room days (excluding swing-bed and observation bed days)			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,672 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,252 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,566,032 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,566,032 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			3,677,071 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			3,677,071 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.697847 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,001.38 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,566,032 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)			698.81 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			874,910 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)			874,910 41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1
					Component CCN: 14S189		Date/Time Prepared: 12/13/2011 3:00 pm
					Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0	0	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)						252,649	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,127,559	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)						43,019	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						10,574	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						53,593	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						1,073,966	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189 Component CCN: 14S189		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 12/13/2011 3:00 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	126,176	2,566,032	0.049172	0	0	90.00
91.00	Nursing School cost	0	2,566,032	0.000000	0	0	91.00
92.00	Allied health cost	0	2,566,032	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,566,032	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 12/13/2011 3:00 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		10,991,622		30.00
32.00	CORONARY CARE UNIT		1,633,942		32.00
40.00	SUBPROVIDER - IPF		0		40.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.352089	4,402,339	1,550,015	50.00
51.00	RECOVERY ROOM	0.334071	532,972	178,050	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.262117	14,848	3,892	52.00
53.00	ANESTHESIOLOGY	0.276199	1,089,008	300,783	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.242736	2,342,655	568,647	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.334659	63,043	21,098	55.00
56.00	RADIOISOTOPE	0.350115	1,436,908	503,083	56.00
57.00	CT SCAN	0.067751	4,035,155	273,386	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.112281	629,123	70,639	58.00
59.00	CARDIAC CATHETERIZATION	0.822249	283,612	233,200	59.00
60.00	LABORATORY	0.232503	6,408,772	1,490,059	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.214011	3,530,249	755,512	65.00
66.00	PHYSICAL THERAPY	0.391724	499,708	195,748	66.00
67.00	OCCUPATIONAL THERAPY	0.437426	125,437	54,869	67.00
68.00	SPEECH PATHOLOGY	0.267130	72,714	19,424	68.00
69.00	ELECTROCARDIOLOGY	0.384997	626,279	241,116	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.176498	23,091	4,076	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274266	3,100,589	850,386	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.395472	5,251,200	2,076,703	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.235429	10,709,704	2,521,375	73.00
75.00	ASC (NON-DISTINCT PART)	0.173522	0	0	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.656758	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	EMERGENCY	0.236901	2,730,319	646,815	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.498306	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		47,907,725	12,558,876	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)		47,907,725		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3	
		Component CCN: 14S189		Date/Time Prepared: 12/13/2011 3:00 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
32.00	CORONARY CARE UNIT		0		32.00
40.00	SUBPROVIDER - IPF		1,250,492		40.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.352089	3,467	1,221	50.00
51.00	RECOVERY ROOM	0.334071	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.262117	0	0	52.00
53.00	ANESTHESIOLOGY	0.276199	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.242736	16,638	4,039	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.334659	0	0	55.00
56.00	RADIOISOTOPE	0.350115	6,051	2,119	56.00
57.00	CT SCAN	0.067751	42,730	2,895	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.112281	13,123	1,473	58.00
59.00	CARDIAC CATHETERIZATION	0.822249	0	0	59.00
60.00	LABORATORY	0.232503	283,727	65,967	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.214011	101,621	21,748	65.00
66.00	PHYSICAL THERAPY	0.391724	4,684	1,835	66.00
67.00	OCCUPATIONAL THERAPY	0.437426	1,752	766	67.00
68.00	SPEECH PATHOLOGY	0.267130	1,108	296	68.00
69.00	ELECTROCARDIOLOGY	0.384997	5,218	2,009	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.176498	680	120	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.274266	2,635	723	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.395472	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.235429	426,256	100,353	73.00
75.00	ASC (NON-DISTINCT PART)	0.173522	0	0	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.656758	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	EMERGENCY	0.236901	198,755	47,085	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.498306	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,108,445	252,649	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)		1,108,445		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part A Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		16,161,980	1.00
2.00	Outlier payments for discharges. (see instructions)		140,671	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		90.90	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		343.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		14.25	31.00
32.00	Sum of lines 30 and 31		357.25	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.61	33.00
34.00	Disproportionate share adjustment (see instructions)		906,687	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		17,209,338	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		19,654,384	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		19,654,384	49.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part A Date/Time Prepared: 12/13/2011 3:00 pm	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,308,896	1.01	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		20,963,280		59.00
60.00	Primary payer payments		4,821		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		20,958,459		61.00
62.00	Deductibles billed to program beneficiaries		2,230,452		62.00
63.00	Coinsurance billed to program beneficiaries		19,789		63.00
64.00	Allowable bad debts (see instructions)		518,738		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		363,117		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		19,071,335		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1		0		70.96
70.97	Low Volume Payment-2		0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		19,071,335		71.00
72.00	Interim payments		18,697,882		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)		373,453		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			-2,068 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			15,454,558 2.00
3.00	PPS payments			13,734,782 3.00
4.00	Outlier payment (see instructions)			25,122 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)			-2,068 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			-2,971 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)			-2,971 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)			-2,971 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)			903 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			-2,971 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)			13,759,904 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,380,646 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)			10,376,287 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)			10,376,287 30.00
31.00	Primary payer payments			757 31.00
32.00	Subtotal (line 30 minus line 31)			10,375,530 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)			683,318 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			478,323 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			10,853,853 37.00
38.00	MSP-LCC reconciliation amount from PS&R			-18 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)			10,853,871 40.00
41.00	Interim payments			11,509,329 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)			-655,458 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			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)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			0 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			0 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			0 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			0 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			0 37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)			0 40.00
41.00	Interim payments			0 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 140189		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 12/13/2011 3:00 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		18,359,899		11,526,684	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	01/26/2011	337,983		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	01/26/2011	0		17,355	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)		337,983		-17,355	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)		18,697,882		11,509,329	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		373,453		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		655,458	6.02	
7.00	Total Medicare program liability (see instructions)		19,071,335		10,853,871	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: 140189 Component CCN: 14S189		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 12/13/2011 3:00 pm	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		805,846		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		805,846		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		61,908		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		867,754		0	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part II Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			990,870 1.00
2.00	Net IPF PPS Outlier Payments			1,996 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			10.060274 9.00
10.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9))) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			992,866 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition			0 14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			992,866 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			992,866 18.00
19.00	Deductibles			181,796 19.00
20.00	Subtotal (line 18 minus line 19)			811,070 20.00
21.00	Coinurance			5,225 21.00
22.00	Subtotal (line 20 minus line 21)			805,845 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			88,442 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			61,909 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			867,754 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			867,754 31.00
32.00	Interim payments			805,846 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)			61,908 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet G Date/Time Prepared: 12/13/2011 3:00 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	20,519,159	0	0	0	1.00
2.00	Temporary investments	5,004,043	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	55,749,602	0	0	0	4.00
5.00	Other receivable	-30,394,326	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	2,338,350	0	0	0	6.00
7.00	Inventory	3,103,841	0	0	0	7.00
8.00	Prepaid expenses	4,793,209	0	0	0	8.00
9.00	Other current assets	0	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)	61,113,878	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,194,269	0	0	0	12.00
13.00	Land improvements	6,306,299	0	0	0	13.00
14.00	Accumulated depreciation	-3,181,517	0	0	0	14.00
15.00	Buildings	80,617,518	0	0	0	15.00
16.00	Accumulated depreciation	-37,196,458	0	0	0	16.00
17.00	Leasehold improvements	105,830	0	0	0	17.00
18.00	Accumulated depreciation	-57,046	0	0	0	18.00
19.00	Fixed equipment	13,954,768	0	0	0	19.00
20.00	Accumulated depreciation	-10,845,281	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	75,615,573	0	0	0	23.00
24.00	Accumulated depreciation	-58,417,212	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	70,096,743	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	76,737,917	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	67,423,034	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	144,160,951	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	275,371,572	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,519,327	0	0	0	37.00
38.00	Salaries, wages, and fees payable	14,719,914	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,481,604	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	0	0	0	0	43.00
44.00	Other current liabilities	4,296,423	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	26,017,268	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	67,721,003	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	67,721,003	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	93,738,271	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	181,633,301	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)	181,633,301	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	275,371,572	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140189

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

Worksheet G-1

Date/Time Prepared:
12/13/2011 3:00 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		156,232,421		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		25,400,883			2.00
3.00	Total (sum of line 1 and line 2)		181,633,304		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)		181,633,304		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)		181,633,304		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140189

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

Worksheet G-1

Date/Time Prepared:
12/13/2011 3:00 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00		0			0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00		0			0	10.00
11.00		0			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		0			0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140189

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

Worksheet G-2 Parts

Date/Time Prepared:
12/13/2011 3:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,925,164		19,925,164	1.00
2.00	SUBPROVIDER - IPF	3,677,071		3,677,071	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	23,602,235		23,602,235	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT	2,889,140		2,889,140	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)	2,889,140		2,889,140	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	26,491,375		26,491,375	17.00
18.00	Ancillary services	91,831,507	244,805,871	336,637,378	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	501,953	501,953	20.00
20.01	RURAL HEALTH CLINIC II	0	366,283	366,283	20.01
20.02	RURAL HEALTH CLINIC III	0	884,913	884,913	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		4,998,212	4,998,212	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	4,808,711	4,808,711	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	118,322,882	256,365,943	374,688,825	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		171,495,132		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)		171,495,132		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 12/13/2011 3:00 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	374,688,825	1.00
2.00	Less contractual allowances and discounts on patients' accounts	229,933,875	2.00
3.00	Net patient revenues (line 1 minus line 2)	144,754,950	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	171,495,132	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-26,740,182	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	27,525	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	140,170	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	622,907	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	83,395	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	18,858	21.00
22.00	Rental of hospital space	361,092	22.00
23.00	Governmental appropriations	50,887,118	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	52,141,065	25.00
26.00	Total (line 5 plus line 25)	25,400,883	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	25,400,883	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet H
		HHA CCN: 147594		Date/Time Prepared: 12/13/2011 3:00 pm
			Home Health Agency I	PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	700,624	177,390	98,531	191,305	206,286	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,184,674	0	0	0	0	6.00
7.00	Physical Therapy	303,590	0	0	0	0	7.00
8.00	Occupational Therapy	101,937	0	0	0	0	8.00
9.00	Speech Pathology	31,464	0	0	0	0	9.00
10.00	Medical Social Services	40,260	0	0	0	0	10.00
11.00	Home Health Aide	100,476	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,463,025	177,390	98,531	191,305	206,286	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet H
		HHA CCN: 147594		Date/Time Prepared: 12/13/2011 3:00 pm
			Home Health Agency I	PPS

		Total (sum of col. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	1,374,136	0	1,374,136	0	1,374,136	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,184,674	0	1,184,674	0	1,184,674	6.00
7.00	Physical Therapy	303,590	0	303,590	0	303,590	7.00
8.00	Occupational Therapy	101,937	0	101,937	0	101,937	8.00
9.00	Speech Pathology	31,464	0	31,464	0	31,464	9.00
10.00	Medical Social Services	40,260	0	40,260	0	40,260	10.00
11.00	Home Health Aide	100,476	0	100,476	0	100,476	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,136,537	0	3,136,537	0	3,136,537	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST	Provider CCN: 140189	Period: From 07/01/2010	Worksheet H-1 Part I Date/Time Prepared: 12/13/2011 3:00 pm
	HHA CCN: 147594	To 06/30/2011	
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	1,374,136	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	1,184,674	0	0	0	6.00
7.00	Physical Therapy	303,590	0	0	0	7.00
8.00	Occupational Therapy	101,937	0	0	0	8.00
9.00	Speech Pathology	31,464	0	0	0	9.00
10.00	Medical Social Services	40,260	0	0	0	10.00
11.00	Home Health Aide	100,476	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,136,537	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet H-1 Part I Date/Time Prepared: 12/13/2011 3:00 pm
		HHA CCN: 147594	Home Health Agency I	PPS

	Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures	0		1.00
2.00	Capital Related - Movable Equipment	0		2.00
3.00	Plant Operations & Maintenance	0		3.00
4.00	Transportation			4.00
5.00	Administrative and General	1,374,136	1,374,136	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	1,184,674	923,684	2,108,358
7.00	Physical Therapy	303,590	236,708	540,298
8.00	Occupational Therapy	101,937	79,480	181,417
9.00	Speech Pathology	31,464	24,532	55,996
10.00	Medical Social Services	40,260	31,391	71,651
11.00	Home Health Aide	100,476	78,341	178,817
12.00	Supplies (see instructions)	0	0	0
13.00	Drugs	0	0	0
14.00	DME	0	0	0
HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0	0
16.00	Respiratory Therapy	0	0	0
17.00	Private Duty Nursing	0	0	0
18.00	Clinic	0	0	0
19.00	Health Promotion Activities	0	0	0
20.00	Day Care Program	0	0	0
21.00	Home Delivered Meals Program	0	0	0
22.00	Homemaker Service	0	0	0
23.00	All Others	0	0	0
24.00	Total (sum of lines 1-23)	1,762,401		3,136,537

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 140189	Period: From 07/01/2010	Worksheet H-1 Part II Date/Time Prepared: 12/13/2011 3:00 pm
	HHA CCN: 147594	To 06/30/2011	
		Home Health Agency I	PPS

	Capital Related Costs				Transportation (MILEAGE)	Reconciliation	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)				
	1.00	2.00	3.00	4.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		3,276			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	3,276	0	0	-1,374,136	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	3,276	0	0	-1,374,136	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 140189	Period: From 07/01/2010	Worksheet H-1 Part II Date/Time Prepared: 12/13/2011 3:00 pm
	HHA CCN: 147594	To 06/30/2011	
		Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	1,762,401	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	1,184,674	6.00
7.00	Physical Therapy	303,590	7.00
8.00	Occupational Therapy	101,937	8.00
9.00	Speech Pathology	31,464	9.00
10.00	Medical Social Services	40,260	10.00
11.00	Home Health Aide	100,476	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others	0	23.00
24.00	Total (sum of lines 1-23)	1,762,401	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	1,374,136	25.00
26.00	Unit Cost Multiplier	0.779695	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	Provider CCN: 140189	Period: From 07/01/2010	Worksheet H-2
	HHA CCN: 147594	To 06/30/2011	Part I Date/Time Prepared: 12/13/2011 3:00 pm
		Home Health Agency I	PPS

	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General	0	21,745	3,153	530,875	555,773	1.00
2.00 Skilled Nursing Care	2,108,358	0	0	0	2,108,358	2.00
3.00 Physical Therapy	540,298	0	0	0	540,298	3.00
4.00 Occupational Therapy	181,417	0	0	0	181,417	4.00
5.00 Speech Pathology	55,996	0	0	0	55,996	5.00
6.00 Medical Social Services	71,651	0	0	0	71,651	6.00
7.00 Home Health Aide	178,817	0	0	0	178,817	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	3,136,537	21,745	3,153	530,875	3,692,310	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 140189 HHA CCN: 147594		Period: From 07/01/2010 To 06/30/2011		Worksheet H-2 Part I Date/Time Prepared: 12/13/2011 3:00 pm PPS	
		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	107,801	50,426	0	12,983	0	1.00
2.00	Skilled Nursing Care	408,951	0	0	0	0	2.00
3.00	Physical Therapy	104,799	0	0	0	0	3.00
4.00	Occupational Therapy	35,189	0	0	0	0	4.00
5.00	Speech Pathology	10,861	0	0	0	0	5.00
6.00	Medical Social Services	13,898	0	0	0	0	6.00
7.00	Home Health Aide	34,684	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	716,183	50,426	0	12,983	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part I Date/Time Prepared: 12/13/2011 3:00 pm
		HHA CCN: 147594	Home Health Agency I	PPS

	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	21,895	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	21,895	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part I Date/Time Prepared: 12/13/2011 3:00 pm
		HHA CCN: 147594	Home Health Agency I	PPS

	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	748,878	0	748,878			1.00
2.00 Skilled Nursing Care	2,517,309	0	2,517,309	503,391	3,020,700	2.00
3.00 Physical Therapy	645,097	0	645,097	129,001	774,098	3.00
4.00 Occupational Therapy	216,606	0	216,606	43,315	259,921	4.00
5.00 Speech Pathology	66,857	0	66,857	13,370	80,227	5.00
6.00 Medical Social Services	85,549	0	85,549	17,107	102,656	6.00
7.00 Home Health Aide	213,501	0	213,501	42,694	256,195	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	4,493,797	0	4,493,797	748,878	4,493,797	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.199972		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140189	Period: From 07/01/2010	Worksheet H-2 Part II Date/Time Prepared: 12/13/2011 3:00 pm
	HHA CCN: 147594	To 06/30/2011	
		Home Health Agency I	PPS

	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
1.00	Administrative and General	3,276	3,405	2,463,025	5A	555,773	1.00
2.00	Skilled Nursing Care	0	0	0	0	2,108,358	2.00
3.00	Physical Therapy	0	0	0	0	540,298	3.00
4.00	Occupational Therapy	0	0	0	0	181,417	4.00
5.00	Speech Pathology	0	0	0	0	55,996	5.00
6.00	Medical Social Services	0	0	0	0	71,651	6.00
7.00	Home Health Aide	0	0	0	0	178,817	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	3,276	3,405	2,463,025		3,692,310	20.00
21.00	Total cost to be allocated	21,745	3,153	530,875		716,183	21.00
22.00	Unit cost multiplier	6.637668	0.925991	0.215538		0.193966	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140189	Period: From 07/01/2010	Worksheet H-2 Part II Date/Time Prepared: 12/13/2011 3:00 pm
	HHA CCN: 147594	To 06/30/2011	
		Home Health Agency I	PPS

	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	3,276	0	22	0	19	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	3,276	0	22	0	19	20.00
21.00 Total cost to be allocated	50,426	0	12,983	0	21,895	21.00
22.00 Unit cost multiplier	15.392552	0.000000	590.136364	0.000000	1,152.368421	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140189	Period: From 07/01/2010	Worksheet H-2 Part II Date/Time Prepared: 12/13/2011 3:00 pm
	HHA CCN: 147594	To 06/30/2011	
		Home Health Agency I	PPS

	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	13.00	14.00	15.00	16.00		
1.00	Administrative and General	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others	0	0	0		19.00
20.00	Total (sum of lines 1-19)	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140189 HHA CCN: 147594		Period: From 07/01/2010 To 06/30/2011		Worksheet H-3 Parts I-II Date/Time Prepared: 12/13/2011 3:00 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	3,020,700		3,020,700	17,913	1.00
2.00	Physical Therapy	3.00	774,098	0	774,098	5,334	2.00
3.00	Occupational Therapy	4.00	259,921	0	259,921	1,321	3.00
4.00	Speech Pathology	5.00	80,227	0	80,227	294	4.00
5.00	Medical Social Services	6.00	102,656		102,656	271	5.00
6.00	Home Health Aide	7.00	256,195		256,195	3,614	6.00
7.00	Total (sum of lines 1-6)		4,493,797	0	4,493,797	28,747	7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits		
					Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	0		8.00
8.01	Skilled Nursing Care		50031	0	0		8.01
8.02	Skilled Nursing Care		50013	0	0		8.02
9.00	Physical Therapy		99914	0	0		9.00
9.01	Physical Therapy		50031	0	0		9.01
9.02	Physical Therapy		50013	0	0		9.02
10.00	Occupational Therapy		99914	0	0		10.00
10.01	Occupational Therapy		50031	0	0		10.01
10.02	Occupational Therapy		50013	0	0		10.02
11.00	Speech Pathology		99914	0	0		11.00
11.01	Speech Pathology		50031	0	0		11.01
11.02	Speech Pathology		50013	0	0		11.02
12.00	Medical Social Services		99914	0	0		12.00
12.01	Medical Social Services		50031	0	0		12.01
12.02	Medical Social Services		50013	0	0		12.02
13.00	Home Health Aide		99914	0	0		13.00
13.01	Home Health Aide		50031	0	0		13.01
13.02	Home Health Aide		50013	0	0		13.02
14.00	Total (sum of lines 8-13)			0	0		14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
Cost Center Description			From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
			0	1.00	2.00	3.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.391724	0	0	1.00
2.00	Occupational Therapy		67.00	0.437426	0	0	2.00
3.00	Speech Pathology		68.00	0.267130	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.274266	0	0	4.00
5.00	Cost of Drugs		73.00	0.235429	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 140189 HHA CCN: 147594	Period: From 07/01/2010 To 06/30/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 12/13/2011 3:00 pm
	Title XVIII	Home Health Agency I	PPS

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	168.63	6,325	5,729		1.00
2.00	Physical Therapy	145.13	2,533	1,355		2.00
3.00	Occupational Therapy	196.76	612	354		3.00
4.00	Speech Pathology	272.88	65	88		4.00
5.00	Medical Social Services	378.80	105	84		5.00
6.00	Home Health Aide	70.89	1,206	1,607		6.00
7.00	Total (sum of lines 1-6)		10,846	9,217		7.00
	Cost Center Description	5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
8.01	Skilled Nursing Care					8.01
8.02	Skilled Nursing Care					8.02
9.00	Physical Therapy					9.00
9.01	Physical Therapy					9.01
9.02	Physical Therapy					9.02
10.00	Occupational Therapy					10.00
10.01	Occupational Therapy					10.01
10.02	Occupational Therapy					10.02
11.00	Speech Pathology					11.00
11.01	Speech Pathology					11.01
11.02	Speech Pathology					11.02
12.00	Medical Social Services					12.00
12.01	Medical Social Services					12.01
12.02	Medical Social Services					12.02
13.00	Home Health Aide					13.00
13.01	Home Health Aide					13.01
13.02	Home Health Aide					13.02
14.00	Total (sum of lines 8-13)					14.00
	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B		
		5.00	6.00	7.00	8.00	
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000	0	0	0	15.00
16.00	Cost of Drugs	0.000000	0	0	0	16.00
	Cost Center Description		Transfer to Part I as Indicated			
			4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy		col. 2, line 2.00			1.00
2.00	Occupational Therapy		col. 2, line 3.00			2.00
3.00	Speech Pathology		col. 2, line 4.00			3.00
4.00	Cost of Medical Supplies		col. 2, line 15.00			4.00
5.00	Cost of Drugs		col. 2, line 16.00			5.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 140189	Period:	Worksheet H-3
	HHA CCN: 147594	From 07/01/2010 To 06/30/2011	Parts I-III Date/Time Prepared: 12/13/2011 3:00 pm
	Title XVIII	Home Health Agency I	PPS

Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)		
	Part A	Part B				
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	9.00	10.00	11.00	12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	1,066,585	966,081		2,032,666	1.00
2.00	Physical Therapy	367,614	196,651		564,265	2.00
3.00	Occupational Therapy	120,417	69,653		190,070	3.00
4.00	Speech Pathology	17,737	24,013		41,750	4.00
5.00	Medical Social Services	39,774	31,819		71,593	5.00
6.00	Home Health Aide	85,493	113,920		199,413	6.00
7.00	Total (sum of lines 1-6)	1,697,620	1,402,137		3,099,757	7.00
Cost Center Description						
		10.00	11.00	12.00		
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
8.01	Skilled Nursing Care					8.01
8.02	Skilled Nursing Care					8.02
9.00	Physical Therapy					9.00
9.01	Physical Therapy					9.01
9.02	Physical Therapy					9.02
10.00	Occupational Therapy					10.00
10.01	Occupational Therapy					10.01
10.02	Occupational Therapy					10.02
11.00	Speech Pathology					11.00
11.01	Speech Pathology					11.01
11.02	Speech Pathology					11.02
12.00	Medical Social Services					12.00
12.01	Medical Social Services					12.01
12.02	Medical Social Services					12.02
13.00	Home Health Aide					13.00
13.01	Home Health Aide					13.01
13.02	Home Health Aide					13.02
14.00	Total (sum of lines 8-13)					14.00
Cost of Services						
Cost Center Description	Part A	Part B				
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	9.00	10.00	11.00			
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0	0	0		15.00
16.00	Cost of Drugs	0	0	0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140189 HHA CCN: 147594	Period: From 07/01/2010 To 06/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	1,871,649	1,578,042	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	1,871,649	1,578,042	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	1,871,649	1,578,042	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		1,471,396	1,210,121
12.00	Total PPS Reimbursement - Full Episodes with Outliers		27,701	24,567
13.00	Total PPS Reimbursement - LUPA Episodes		16,257	28,440
14.00	Total PPS Reimbursement - PEP Episodes		17,813	5,804
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		6,850	7,142
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		1,540,017	1,276,074
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		1,540,017	1,276,074
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		1,540,017	1,276,074
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		1,540,017	1,276,074
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		1,540,017	1,276,074
32.00	Interim payments (see instructions)		1,540,017	1,276,074
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet H-5
	HHA CCN: 147594	Home Health Agency I	Date/Time Prepared: 12/13/2011 3:00 pm PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,540,017		1,276,074	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		1,540,017		1,276,074	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,540,017		1,276,074	7.00
			0	Contractor Number	Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140189

Period: From 07/01/2010

Worksheet K

Hospice CCN: 141599

To 06/30/2011

Date/Time Prepared: 12/13/2011 3:00 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	220,711	0	0	0	679,195	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	896,972	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	1,238	0	0	0	0	12.00
13.00	Occupational Therapy	373	0	0	0	0	13.00
14.00	Speech/ Language Pathology	206	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,119,500	0	0	0	679,195	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140189

Period: From 07/01/2010

Worksheet K

Hospice CCN: 141599

To 06/30/2011

Date/Time Prepared: 12/13/2011 3:00 pm

		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	899,906	0	899,906	0	899,906	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	896,972	0	896,972	0	896,972	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	1,238	0	1,238	0	1,238	12.00
13.00	Occupational Therapy	373	0	373	0	373	13.00
14.00	Speech/ Language Pathology	206	0	206	0	206	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,798,695	0	1,798,695	0	1,798,695	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189

Period: From 07/01/2010

Worksheet K-1

Hospice CCN: 141599

To 06/30/2011

Date/Time Prepared: 12/13/2011 3:00 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	129,552	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	151,515	0	633,185	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	129,552	151,515	0	633,185	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189

Period: From 07/01/2010

Worksheet K-1

Hospice CCN: 141599

To 06/30/2011

Date/Time Prepared: 12/13/2011 3:00 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	91,159	220,711	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		112,272	0	896,972	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	1,238	0	0	1,238	12.00
13.00	Occupational Therapy	373	0	0	373	13.00
14.00	Speech/ Language Pathology	206	0	0	206	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,817	112,272	91,159	1,119,500	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189

Period: From 07/01/2010

Worksheet K-4

Hospice CCN: 141599

To 06/30/2011

Part I
Date/Time Prepared:
12/13/2011 3:00 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	899,906	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	896,972	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	1,238	0	0	0	0	12.00
13.00	Occupational Therapy	373	0	0	0	0	13.00
14.00	Speech/ Language Pathology	206	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,798,695	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189

Period: From 07/01/2010

Worksheet K-4

Hospice CCN: 141599

To 06/30/2011

Part I
Date/Time Prepared:
12/13/2011 3:00 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.		0			1.00
2.00	Capital Related Costs-Movable Equip.		0			2.00
3.00	Plant Operation and Maintenance		0			3.00
4.00	Transportation - Staff		0			4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	899,906			6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	896,972	898,087	1,795,059	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	1,238	1,240	2,478	12.00
13.00	Occupational Therapy	0	373	373	746	13.00
14.00	Speech/ Language Pathology	0	206	206	412	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	898,789	899,906	1,798,695	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

Period: From 07/01/2010

Worksheet K-4

Hospice CCN: 141599

To 06/30/2011

Part II
Date/Time Prepared:
12/13/2011 3:00 pm

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189
 Hospice CCN: 141599

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 12/13/2011 3:00 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-899,906	898,789	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	896,972	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	1,238	12.00
13.00	Occupational Therapy	0	373	13.00
14.00	Speech/ Language Pathology	0	206	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		899,906	39.00
40.00	Unit Cost Multiplier		1.001243	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	Provider CCN: 140189	Period: 07/01/2010	Worksheet K-5
	Hospice CCN: 141599	To 06/30/2011	Part I Date/Time Prepared: 12/13/2011 3:00 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
1.00 Administrative and General	0	15,532	423	241,295	257,250	1.00
2.00 Inpatient - General Care	1,795,059	0	0	0	1,795,059	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	2,478	0	0	0	2,478	7.00
8.00 Occupational Therapy	746	0	0	0	746	8.00
9.00 Speech/ Language Pathology	412	0	0	0	412	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	1,798,695	15,532	423	241,295	2,055,945	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 140189	Period: From 07/01/2010	Worksheet K-5
		Hospice CCN: 141599	To 06/30/2011	Part I
				Date/Time Prepared: 12/13/2011 3:00 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	49,898	36,019	0	9,442	0	1.00
2.00	Inpatient - General Care	348,179	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	481	0	0	0	0	7.00
8.00	Occupational Therapy	145	0	0	0	0	8.00
9.00	Speech/ Language Pathology	80	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specif y	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	398,783	36,019	0	9,442	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	Provi der CCN: 140189	Peri od: 07/01/2010	Worksheet K-5
	Hospi ce CCN: 141599	To 06/30/2011	Part I Date/Time Prepared: 12/13/2011 3:00 pm

Cost Center Description	Hospi ce I					
	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	19,590	0	0	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	19,590	0	0	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet K-5 Part I Date/Time Prepared: 12/13/2011 3:00 pm
	Hospice CCN: 141599		

Cost Center Description	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	372,199					1.00
2.00 Inpatient - General Care	2,143,238	0	2,143,238	371,447	2,514,685	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	2,959	0	2,959	513	3,472	7.00
8.00 Occupational Therapy	891	0	891	154	1,045	8.00
9.00 Speech/ Language Pathology	492	0	492	85	577	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	2,519,779	0	2,519,779		2,519,779	34.00
35.00 Unit Cost Multiplier (see instructions)				0.173311		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS	Provider CCN: 140189	Period: From 07/01/2010	Worksheet K-5 Part II Date/Time Prepared: 12/13/2011 3:00 pm
	Hospice CCN: 141599	To 06/30/2011	

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00	4.00	5A	5.00	
1.00 Administrative and General	15,532	423	241,295	0	257,250	1.00
2.00 Inpatient - General Care	0	0	0	0	1,795,059	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	2,478	7.00
8.00 Occupational Therapy	0	0	0	0	746	8.00
9.00 Speech/ Language Pathology	0	0	0	0	412	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	15,532	423	241,295		2,055,945	34.00
35.00 Total cost to be allocated	15,532	423	241,295		398,783	35.00
36.00 Unit Cost Multiplier (see instructions)	1.000000	1.000000	1.000000		0.193966	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS	Provi der CCN: 140189	Peri od: From 07/01/2010	Worksheet K-5 Part II Date/Time Prepared: 12/13/2011 3:00 pm
	Hospi ce CCN: 141599	To 06/30/2011	

Cost Center Description	Hospi ce I						
	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)		
	7.00	8.00	9.00	10.00	11.00		
1.00 Administrative and General	36,019	0	9,442	0	19,590	1.00	
2.00 Inpatient - General Care	0	0	0	0	0	2.00	
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00	
4.00 Physician Services	0	0	0	0	0	4.00	
5.00 Nursing Care	0	0	0	0	0	5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00	
7.00 Physical Therapy	0	0	0	0	0	7.00	
8.00 Occupational Therapy	0	0	0	0	0	8.00	
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00	
10.00 Medical Social Services	0	0	0	0	0	10.00	
11.00 Spiritual Counseling	0	0	0	0	0	11.00	
12.00 Dietary Counseling	0	0	0	0	0	12.00	
13.00 Counseling - Other	0	0	0	0	0	13.00	
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00	
16.00 Other	0	0	0	0	0	16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00	
18.00 Anal gesi cs	0	0	0	0	0	18.00	
19.00 Sedati ves / Hypnoti cs	0	0	0	0	0	19.00	
20.00 Other - Speci fy	0	0	0	0	0	20.00	
21.00 Durabl e Medi cal Equi pment/Oxygen	0	0	0	0	0	21.00	
22.00 Pati ent Transportati on	0	0	0	0	0	22.00	
23.00 Imagi ng Servi ces	0	0	0	0	0	23.00	
24.00 Labs and Di agnosti cs	0	0	0	0	0	24.00	
25.00 Medi cal Suppl i es	0	0	0	0	0	25.00	
26.00 Outpati ent Servi ces (i ncl udi ng E/R Dept.)	0	0	0	0	0	26.00	
27.00 Radi ati on Therapy	0	0	0	0	0	27.00	
28.00 Chemotherap y	0	0	0	0	0	28.00	
29.00 Other	0	0	0	0	0	29.00	
30.00 Bereavement Program Costs	0	0	0	0	0	30.00	
31.00 Vol unteer Program Costs	0	0	0	0	0	31.00	
32.00 Fundrai si ng	0	0	0	0	0	32.00	
33.00 Other Program Costs	0	0	0	0	0	33.00	
34.00 Total (sum of lines 1 thru 33) (2)	36,019	0	9,442	0	19,590	34.00	
35.00 Total cost to be allocated	36,019	0	9,442	0	19,590	35.00	
36.00 Unit Cost Multi pl i er (see i nstru ctions)	1.000000	0.000000	1.000000	0.000000	1.000000	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189

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

Worksheet K-5
Part II
Date/Time Prepared:
12/13/2011 3:00 pm

Cost Center Description	Hospice I					
	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	0	0	0		1.00
2.00 Inpatient - General Care	0	0	0	0		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	0	0	0		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00 Physical Therapy	0	0	0	0		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Spiritual Counseling	0	0	0	0		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - Other	0	0	0	0		13.00
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	0	0	0		19.00
20.00 Other - Specify	0	0	0	0		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	0		34.00
35.00 Total cost to be allocated	0	0	0	0		35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 140189	Period: From 07/01/2010	Worksheet K-5 Part III Date/Time Prepared: 12/13/2011 3:00 pm
		Hospice CCN: 141599	To 06/30/2011	

Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.391724	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.437426	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.267130	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.235429	0	0	4.00
5.00	DURABLE MEDICAL EQUIP. - RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.232503	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.274266	0	0	7.00
7.01	IMPLANTABLE DEVICES CHARGED TO PATIENTS	71.01				7.01
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.334659	0	0	9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	3.656758	0	0	10.00
11.00	Totals (sum of lines 1-10)					11.00

CALCULATION OF HOSPICE PER DIEM COST	Provider CCN: 140189	Period: From 07/01/2010	Worksheet K-6
	Hospice CCN: 141599	To 06/30/2011	Date/Time Prepared: 12/13/2011 3:00 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				2,519,779	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				20,876	2.00
3.00	Average cost per diem (line 1 divided by line 2)				120.70	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	18,289				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	2,207,482				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		1,361			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		164,273			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	7,952				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	959,806				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		182			10.00
11.00	Aggregate NF cost (line 3 times line 10)		21,967			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			1,226		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			147,978		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet L Parts I-III Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,298,172	1.00
2.00	Capital DRG outlier payments		10,724	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		57.52	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,308,896	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 12/13/2011 3:00 pm
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		Title XVIII		Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	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	0	0	0	0	0
2.00	Physician Assistant	86,961	6,076	93,037	0	93,037
3.00	Nurse Practitioner	90,096	9,207	99,303	0	99,303
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	108,003	7,618	115,621	0	115,621
10.00	Subtotal (sum of lines 1-9)	285,060	22,901	307,961	0	307,961
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0
15.00	Medical Supplies	0	19,698	19,698	0	19,698
16.00	Transportation (Health Care Staff)	0	2,296	2,296	0	2,296
17.00	Depreciation-Medical Equipment	0	20,422	20,422	0	20,422
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15-20)	0	42,416	42,416	0	42,416
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	285,060	65,317	350,377	0	350,377
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	54,398	54,398	0	54,398
30.00	Administrative Costs	57,286	5,953	63,239	0	63,239
31.00	Total Facility Overhead (sum of lines 29 and 30)	57,286	60,351	117,637	0	117,637
32.00	Total facility costs (sum of lines 22, 28 and 31)	342,346	125,668	468,014	0	468,014

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1
	Component CCN: 143978		Date/Time Prepared: 12/13/2011 3:00 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	93,037	2.00
3.00	Nurse Practitioner	0	99,303	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	115,621	9.00
10.00	Subtotal (sum of lines 1-9)	0	307,961	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	19,698	15.00
16.00	Transportation (Health Care Staff)	0	2,296	16.00
17.00	Depreciation-Medical Equipment	0	20,422	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	42,416	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	350,377	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	54,398	29.00
30.00	Administrative Costs	0	63,239	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	117,637	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	468,014	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 12/13/2011 3:00 pm
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		Title XVIII		Rural Health Clinic (RHC) II	Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	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	129,194	14,238	143,432	0	143,432	1.00
2.00	Physician Assistant	95,477	8,366	103,843	0	103,843	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	85,087	5,843	90,930	0	90,930	9.00
10.00	Subtotal (sum of lines 1-9)	309,758	28,447	338,205	0	338,205	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	28,350	28,350	0	28,350	15.00
16.00	Transportation (Health Care Staff)	0	2,385	2,385	0	2,385	16.00
17.00	Depreciation-Medical Equipment	0	16,825	16,825	0	16,825	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	47,560	47,560	0	47,560	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	309,758	76,007	385,765	0	385,765	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	52,235	52,235	0	52,235	29.00
30.00	Administrative Costs	45,569	6,346	51,915	0	51,915	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	45,569	58,581	104,150	0	104,150	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	355,327	134,588	489,915	0	489,915	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1
	Component CCN: 143998		Date/Time Prepared: 12/13/2011 3:00 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	143,432
2.00	Physician Assistant	0	103,843
3.00	Nurse Practitioner	0	0
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	90,930
10.00	Subtotal (sum of lines 1-9)	0	338,205
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	0
15.00	Medical Supplies	0	28,350
16.00	Transportation (Health Care Staff)	0	2,385
17.00	Depreciation-Medical Equipment	0	16,825
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	47,560
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	385,765
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	52,235
30.00	Administrative Costs	0	51,915
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	104,150
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	489,915

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS			Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1 Date/Time Prepared: 12/13/2011 3:00 pm	
			Title XVIII	Rural Health Clinic (RHC) III	Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	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	0	0	0	0	1.00
2.00	Physician Assistant	239,595	11,957	251,552	0	2.00
3.00	Nurse Practitioner	58,077	8,432	66,509	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	76,064	6,828	82,892	0	9.00
10.00	Subtotal (sum of lines 1-9)	373,736	27,217	400,953	0	10.00
11.00	Physician Services Under Agreement	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	14.00
15.00	Medical Supplies	0	26,883	26,883	0	15.00
16.00	Transportation (Health Care Staff)	0	347	347	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	20,422	20,422	0	18.00
19.00	Other Health Care Costs	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	47,652	47,652	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	373,736	74,869	448,605	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	37,834	37,834	0	29.00
30.00	Administrative Costs	55,146	6,042	61,188	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	55,146	43,876	99,022	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	428,882	118,745	547,627	0	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1
	Component CCN: 143435		Date/Time Prepared: 12/13/2011 3:00 pm
	Title XVIII	Rural Health Clinic (RHC) III	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	251,552	2.00
3.00	Nurse Practitioner	0	66,509	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	82,892	9.00
10.00	Subtotal (sum of lines 1-9)	0	400,953	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	26,883	15.00
16.00	Transportation (Health Care Staff)	0	347	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	20,422	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	47,652	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	448,605	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	37,834	29.00
30.00	Administrative Costs	0	61,188	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	99,022	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	547,627	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES			Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-2	
			Component CCN: 143978		Date/Time Prepared: 12/13/2011 3:00 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	0.00	0	0	0	1.00
2.00	Physician Assistant	0.70	3,375	2,100	1,470	2.00
3.00	Nurse Practitioner	1.00	1,188	2,100	2,100	3.00
4.00	Subtotal (sum of lines 1-3)	1.70	4,563		3,570	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.70	4,563			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)				350,377	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)				350,377	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)				117,637	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				526,453	15.00
16.00	Total overhead (sum of lines 14 and 15)				644,090	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				644,090	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				644,090	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				994,467	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-2
		Component CCN: 143998		Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.49	203	2,100	1,029	1.00
2.00	Physician Assistant	1.00	2,658	2,100	2,100	2.00
3.00	Nurse Practitioner	0.00	0	0	0	3.00
4.00	Subtotal (sum of lines 1-3)	1.49	2,861		3,129	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.49	2,861		3,129	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)			385,765	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)			385,765	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)			104,150	14.00
15.00	Parent provider overhead allocated to facility (see instructions)			352,684	15.00
16.00	Total overhead (sum of lines 14 and 15)			456,834	16.00
17.00	Allowable GME overhead (see instructions)			0	17.00
18.00	Subtract line 17 from line 16			456,834	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)			456,834	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)			842,599	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-2		
		Component CCN: 143435		Date/Time Prepared: 12/13/2011 3:00 pm		
		Title XVIII	Rural Health Clinic (RHC) III	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	0	0	1.00
2.00	Physician Assistant	1.00	5,033	2,100	2,100	2.00
3.00	Nurse Practitioner	0.66	659	2,100	1,386	3.00
4.00	Subtotal (sum of lines 1-3)	1.66	5,692		3,486	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.66	5,692		5,692	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)				448,605	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)				448,605	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)				99,022	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				291,226	15.00
16.00	Total overhead (sum of lines 14 and 15)				390,248	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				390,248	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				390,248	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				838,853	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3	
		Component CCN: 143978		Date/Time Prepared: 12/13/2011 3:00 pm	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
				1.00	
DETERMINATION OF RATE FOR RHC/FQHC SERVICES					
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)			994,467	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)			7,487	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			986,980	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)			4,563	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)			4,563	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			216.30	7.00
			Calculation of Limit (1)		
			Prior to January 1	On or After January 1	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)		77.76	77.76	8.00
9.00	Rate for Program covered visits (see instructions)		77.76	77.76	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		442	506	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		34,370	39,347	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) *		34,370	39,347	16.00
16.01	Total program charges (see instructions)(from contractor's records)			105,960	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%)			15,934	16.04
16.05	Total program cost (see instructions)		27,496	15,934	16.05
17.00	Primary payer amounts			101	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			19,430	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			16,893	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			43,329	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			671	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			44,000	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)			44,000	26.00
27.00	Interim payments			42,864	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)			1,136	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter I, section 115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3
		Component CCN: 143998		Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		842,599	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		8,071	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		834,528	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,129	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)		3,129	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		266.71	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	77.76	77.76	8.00
9.00	Rate for Program covered visits (see instructions)	77.76	77.76	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	235	311	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	18,274	24,183	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) *	18,274	24,183	16.00
16.01	Total program charges (see instructions)(from contractor's records)		71,646	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%)		12,126	16.04
16.05	Total program cost (see instructions)	14,619	12,126	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,025	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,526	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		26,745	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,367	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		28,112	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)		28,112	26.00
27.00	Interim payments		26,290	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)		1,822	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3
		Component CCN: 143435		Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		838,853	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		5,805	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		833,048	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,692	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,692	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		146.35	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	77.76	77.76	8.00
9.00	Rate for Program covered visits (see instructions)	77.76	77.76	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	455	490	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	35,381	38,102	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) *	35,381	38,102	16.00
16.01	Total program charges (see instructions)(from contractor's records)		134,775	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%)		15,806	16.04
16.05	Total program cost (see instructions)	28,305	15,806	16.05
17.00	Primary payer amounts		227	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18,345	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		23,256	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		43,884	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		284	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		44,168	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)		44,168	26.00
27.00	Interim payments		42,753	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)		1,415	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2010 To 06/30/2011	Worksheet M-4 Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	307,961	307,961	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,320	1,318	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,320	1,318	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	350,377	350,377	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	644,090	644,090	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003767	0.003762	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,426	2,423	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,746	3,741	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	32	131	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	117.06	28.56	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	3	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	585	86	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		7,487	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)		671	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2010 To 06/30/2011	Worksheet M-4 Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	338,205	338,205	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	908	2,787	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	908	2,787	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	385,765	385,765	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	456,834	456,834	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002354	0.007225	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,075	3,301	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,983	6,088	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	22	277	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	90.14	21.98	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	54	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	180	1,187	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)		8,071	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)		1,367	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2010 To 06/30/2011	Worksheet M-4 Date/Time Prepared: 12/13/2011 3:00 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	400,953	400,953	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,032	2,072	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,032	2,072	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	448,605	448,605	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	390,248	390,248	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002300	0.004619	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	898	1,803	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,930	3,875	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	25	206	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	77.20	18.81	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	11	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	77	207	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)		5,805	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)		284	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5
	Component CCN: 143978		Date/Time Prepared: 12/13/2011 3:00 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		42,864	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		42,864	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,136	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		44,000	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 12/13/2011 3:00 pm	
		Title XVIII	Rural Health Clinic (RHC) II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider			26,290	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			26,290	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			1,822	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			28,112	7.00
			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 12/13/2011 3:00 pm	
		Title XVIII	Rural Health Clinic (RHC) III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider			42,753	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			42,753	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			1,415	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			44,168	7.00
			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00