

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: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 4/17/2012 9:54 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" 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: 3/20/2012 Time: 10:06 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 MASON DISTRICT HOSPITAL for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title 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	318,055	-204,767	0	0 1.00
2.00 Subprovider - IPF	0	0	0	0	0 2.00
3.00 Subprovider - IRF	0	0	0	0	0 3.00
4.00 SUBPROVIDER I	0	0	0	0	0 4.00
5.00 Swing bed - SNF	0	255,985	0	0	0 5.00
6.00 Swing bed - NF	0	0	0	0	0 6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0 7.00
8.00 NURSING FACILITY	0	0	0	0	0 8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00 RURAL HEALTH CLINIC I	0	0	-33,293	0	0 10.00
10.01 RURAL HEALTH CLINIC II II	0	0	4,283	0	0 10.01
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0 11.00
12.00 CMHC I	0	0	0	0	0 12.00
200.00 Total	0	574,040	-233,777	0	0 200.00

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

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

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PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended
 6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 3/20/2012 Time: 10:06 am

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Encryption Information
 ECR: Date: 3/20/2012 Time: 10:06 am
 fFODu9Fy7q4Wp8PrLI f1n4nTBgNI 00
 qI cB708hj NmbQ. 7hRfQWTi GmHJhnmI
 WXV90Z2I : d0s. hnf
 PI: Date: 3/20/2012 Time: 10:06 am
 7Ekzkfr01WHQx: eXhI yyPNyXBo0o50
 6hkZ20eeWx203i GH4Hl . MLmeX5Heyr
 5ZXhUVHEuF0Gni aT

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	318,055	-204,767	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	255,985	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	-33,293	0	0	10.00
10.01 RURAL HEALTH CLINIC II II	0	0	4,283	0	0	10.01
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	574,040	-233,777	0	0	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141313		Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 4/17/2012 9:54 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 615 NORTH PROMENADE STREET			PO Box:						1.00	
2.00	City: HAVANA			State: IL		Zip Code: 62644-0530		County: MASON		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		MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	N	O	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		MASON DISTRICT HOSPITAL	14Z313	99914		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF							N		N	8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		MASON DISTRICT HHA	147202	99914		01/09/1982	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	0	0	0	15.00
15.01	Hospital-Based Health Clinic - RHC 1		MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	0	0	0	15.01
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) 1										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2010	09/30/2011		20.00	
21.00	Type of Control (see instructions)						11		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						3		N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.			0	0	0	0	0	0	25.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.								2	26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.								2	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0	35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 4/17/2012 9:54 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000		64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141313

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

Worksheet S-2
Part I
Date/Time Prepared:
4/17/2012 9:54 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00	
						1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00	

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			1.00	2.00	3.00
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
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		Y		108.00
			Physical	Occupational	Speech
			1.00	2.00	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	109.00
			1.00		2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		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.		1,000,000	3,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141313		Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 4/17/2012 9:54 am	
		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N				140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			141.00
142.00	Street:	PO Box:		Zip Code:			142.00
143.00	City:	State:					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		N		N		158.00
159.00	SNF		N		N		159.00
160.00	HOME HEALTH AGENCY		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	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						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: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 4/17/2012 9:54 am
			Y/N 1.00	Date 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 1.00	Date 2.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
			Y/N 1.00	Type 2.00
				Date 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.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
				Y/N 1.00
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/13/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 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		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/13/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	20,241.50		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	20,241.50		7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	20,241.50		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.01 RURAL HEALTH CLINIC II	88.01					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
4/17/2012 9:54 am

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	672	50	879		1.00
2.00 HMO		29	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	523	0	545		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	95		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,195	50	1,519		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0	1,195	50	1,519		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	5,804	0	16,805		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	5,285	0	15,852		26.00
26.01 RURAL HEALTH CLINIC II	0	327	0	1,554		26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	131		28.00
29.00 Ambulance Trips		621				29.00
30.00 Employee discount days (see instruction)				1		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: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
4/17/2012 9:54 am

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	242	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	163.67	0.00	0	242	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	10.81	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	29.88	0.00			26.00
26.01 RURAL HEALTH CLINIC II	0.00	3.13	0.00			26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	207.49	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141313

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

Worksheet S-3
Part I
Date/Time Prepared:
4/17/2012 9:54 am

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)	20	337		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)	20	337		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.01 RURAL HEALTH CLINIC II				26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 141313 Component CCN: 147202		Period: From 10/01/2010 To 09/30/2011		Worksheet S-4 Date/Time Prepared: 4/17/2012 9:54 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			MASON		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	1,306	0	0	1,306	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	204.00	9.00	43.00	256.00	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		0.65	0.00	0.65	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			2.05	0.00	2.05	5.00
6.00	Direct Nursing Service			7.46	0.00	7.46	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.01	0.00	0.01	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.63	0.00	0.63	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.			1			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
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	3,594	88	81	7	3,770	21.00
22.00	Skilled Nursing Visit Charges	780,012	19,174	17,586	1,526	818,298	22.00
23.00	Physical Therapy Visits	877	25	17	0	919	23.00
24.00	Physical Therapy Visit Charges	210,475	6,025	4,097	0	220,597	24.00
25.00	Occupational Therapy Visits	614	22	5	0	641	25.00
26.00	Occupational Therapy Visit Charges	147,997	5,302	1,205	0	154,504	26.00
27.00	Speech Pathology Visits	7	15	0	0	22	27.00
28.00	Speech Pathology Visit Charges	1,687	3,615	0	0	5,302	28.00
29.00	Medical Social Service Visits	4	0	0	0	4	29.00
30.00	Medical Social Service Visit Charges	964	0	0	0	964	30.00
31.00	Home Health Aide Visits	429	19	0	0	448	31.00
32.00	Home Health Aide Visit Charges	51,362	2,280	0	0	53,642	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,525	169	103	7	5,804	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,192,497	36,396	22,888	1,526	1,253,307	35.00
36.00	Total Number of Episodes (standard/non outlier)	283		37	1	321	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	5,404	216	1,128	0	6,748	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 4/17/2012 9:54 am	
			Rural Health Clinic (RHC) I	Cost	
				1.00	
1.00	Clinic Address and Identification Street		615 PROMENADE BOX 530	1.00	
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County		HAVANA	IL62644-0530 2.00	
				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 4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			0 5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0 6.00	
7.00	Appalachian Regional Commission			0 7.00	
8.00	Look-Alikes			0 8.00	
9.00	OTHER (SPECIFY)			0 9.00	
			1.00	2.00	
10.00	Does this facility operate as other than an RHC or 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 to		
		1.00 2.00	3.00 4.00		
11.00	Facility hours of operations (1) Clinic		08:00 17:00	11.00	
			1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N 12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N 0 13.00	
			Provider name	CCN number	
			1.00	2.00	
14.00	Provider name, CCN number			14.00	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		N 0	0 0 0 15.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 4/17/2012 9:54 am
			Rural Health Clinic (RHC) I	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	MASON		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: 141313 Component CCN: 143457	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 4/17/2012 9:54 am		
			Rural Health Clinic (RHC) I	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 4/17/2012 9:54 am 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: 141313 Component CCN: 143462	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 4/17/2012 9:54 am
			Rural Health Clinic (RHC) II	Cost
				1.00
1.00	Clinic Address and Identification			1.00
	Street	615 N PROMENADE		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	HAVANA	IL	62644
				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		
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.			N
				0
				12.00
				13.00
			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)			N
			0	0
				0
				0
				15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 4/17/2012 9:54 am
			Rural Health Clinic (RHC) II	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	MASON		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: 141313 Component CCN: 143462	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 4/17/2012 9:54 am		
			Rural Health Clinic (RHC) II	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	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 4/17/2012 9:54 am
		Rural Health Clinic (RHC) II	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet S-10 Date/Time Prepared: 4/17/2012 9:54 am
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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)		0.660546	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		682,367	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		624,602	5.00	
6.00	Medicaid charges		2,157,659	6.00	
7.00	Medicaid cost (line 1 times line 6)		1,425,233	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)		118,264	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		11,444	9.00	
10.00	Stand-alone SCHIP charges		22,143	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		14,626	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		3,182	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		1,273,267	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		121,446	19.00	
			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	555,985	44,945	600,930	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	367,254	29,688	396,942	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	367,254	29,688	396,942	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,554,199	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			344,529	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			1,209,670	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			799,043	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			1,195,985	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,317,431	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141313

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

Worksheet A
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		826	826	241,159	241,985	1.00
1.01 NEW CAP REL COSTS-CLINIC BUILDING		0	0	66,844	66,844	1.01
1.02 NEW CAP REL COSTS-NEW MED SURG		0	0	609,358	609,358	1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP		1,018,587	1,018,587	-452,427	566,160	2.00
4.00 EMPLOYEE BENEFITS	0	2,182,047	2,182,047	0	2,182,047	4.00
5.01 ADMINISTRATIVE & GENERAL	850,389	949,527	1,799,916	0	1,799,916	5.01
5.02 ADMIN & GENERAL-HOSPITAL	326,867	207,313	534,180	0	534,180	5.02
6.00 MAINTENANCE & REPAIRS	314,171	183,026	497,197	0	497,197	6.00
7.00 OPERATION OF PLANT	0	230,352	230,352	0	230,352	7.00
7.01 OPERATION OF PLANT-CLINIC	0	17,138	17,138	0	17,138	7.01
8.00 LAUNDRY & LINEN SERVICE	27,267	19,685	46,952	0	46,952	8.00
9.00 HOUSEKEEPING	240,632	76,483	317,115	0	317,115	9.00
10.00 DIETARY	219,389	163,666	383,055	0	383,055	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	202,044	42,406	244,450	0	244,450	13.00
14.00 CENTRAL SERVICES & SUPPLY	73,952	8,158	82,110	0	82,110	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	180,836	39,025	219,861	0	219,861	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	288,783	288,783	0	288,783	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	990,726	164,918	1,155,644	0	1,155,644	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	179,392	69,543	248,935	0	248,935	50.00
53.00 ANESTHESIOLOGY	0	122	122	0	122	53.00
54.00 RADIOLOGY-DIAGNOSTIC	484,128	194,621	678,749	-104,891	573,858	54.00
54.01 RADIOLOGY-ULTRASOUND	62,520	36,924	99,444	2,737	102,181	54.01
56.00 RADIOISOTOPE	48,071	96,330	144,401	871	145,272	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	103,572	103,572	1,532	105,104	58.00
60.00 LABORATORY	615,938	441,313	1,057,251	78,468	1,135,719	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,372	46,372	0	46,372	62.00
64.00 INTRAVENOUS THERAPY	0	10,592	10,592	0	10,592	64.00
66.00 PHYSICAL THERAPY	512,031	129,414	641,445	0	641,445	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 CARDIOPULMONARY	329,259	133,628	462,887	21,283	484,170	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	300,145	300,145	0	300,145	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	266,480	459,036	725,516	0	725,516	73.00
76.00 OP SENIOR HEALTH	253,601	159,498	413,099	0	413,099	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	11,714	11,714	0	11,714	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	2,351,562	457,280	2,808,842	-88,305	2,720,537	88.00
88.01 RURAL HEALTH CLINIC II	184,695	60,094	244,789	0	244,789	88.01
91.00 EMERGENCY	370,975	1,227,552	1,598,527	549,752	2,148,279	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	737,594	89,765	827,359	-549,752	277,607	95.00
101.00 HOME HEALTH AGENCY	553,492	139,903	693,395	0	693,395	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE		464,934	464,934	-464,934	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	10,376,011	10,224,292	20,600,303	-88,305	20,511,998	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	14,289	586	14,875	88,305	103,180	192.00
194.00 HOSPICE	0	0	0	0	0	194.00
194.01 FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02 MEALS ON WHEELS	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00 TOTAL (SUM OF LINES 118-199)	10,390,300	10,224,878	20,615,178	0	20,615,178	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141313

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

Worksheet A
Date/Time Prepared:
4/17/2012 9:54 am

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	-2,910	239,075	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	66,844	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	-6,341	603,017	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	566,160	2.00
4.00	EMPLOYEE BENEFITS	-511,452	1,670,595	4.00
5.01	ADMINISTRATIVE & GENERAL	-35,229	1,764,687	5.01
5.02	ADMIN & GENERAL-HOSPITAL	-9,246	524,934	5.02
6.00	MAINTENANCE & REPAIRS	0	497,197	6.00
7.00	OPERATION OF PLANT	-310	230,042	7.00
7.01	OPERATION OF PLANT-CLINIC	0	17,138	7.01
8.00	LAUNDRY & LINEN SERVICE	0	46,952	8.00
9.00	HOUSEKEEPING	0	317,115	9.00
10.00	DIETARY	-117,736	265,319	10.00
11.00	CAFETERIA	0	0	11.00
13.00	NURSING ADMINISTRATION	0	244,450	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	82,110	14.00
15.00	PHARMACY	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	-6,819	213,042	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	288,783	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,155,644	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	248,935	50.00
53.00	ANESTHESIOLOGY	0	122	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-29,762	544,096	54.00
54.01	RADIOLOGY-ULTRASOUND	0	102,181	54.01
56.00	RADIOISOTOPE	0	145,272	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	105,104	58.00
60.00	LABORATORY	-57	1,135,662	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,372	62.00
64.00	INTRAVENOUS THERAPY	0	10,592	64.00
66.00	PHYSICAL THERAPY	0	641,445	66.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
69.01	CARDIOPULMONARY	-45,346	438,824	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	300,145	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	-823	724,693	73.00
76.00	OP SENIOR HEALTH	0	413,099	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	11,714	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-348	2,720,189	88.00
88.01	RURAL HEALTH CLINIC II	-595	244,194	88.01
91.00	EMERGENCY	-280,020	1,868,259	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	-114	277,493	95.00
101.00	HOME HEALTH AGENCY	-982	692,413	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,048,090	19,463,908	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	103,180	192.00
194.00	HOSPICE	0	0	194.00
194.01	FAMILY MEDICAL CENTER	0	0	194.01
194.02	MEALS ON WHEELS	0	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.04
200.00	TOTAL (SUM OF LINES 118-199)	-1,048,090	19,567,088	200.00

RECLASSIFICATIONS

Provider CCN: 141313

Period:
From 10/01/2010
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Worksheet A-6

Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	149,355	1.00
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	315,579	2.00
TOTALS			0	464,934	
B - EMS SALARY TO ER					
1.00	EMERGENCY	91.00	549,752	0	1.00
TOTALS			549,752	0	
C - CLINIC DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	91,804	1.00
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	66,844	2.00
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	293,779	3.00
TOTALS			0	452,427	
D - RHC PHYSICIAN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	88,305	0	1.00
TOTALS			88,305	0	
E - OP REGISTRATION					
1.00	LABORATORY	60.00	69,660	8,808	1.00
2.00	CARDIOPULMONARY	69.01	18,894	2,389	2.00
3.00	RADIOLOGY-ULTRASOUND	54.01	2,430	307	3.00
4.00	RADIOISOTOPE	56.00	773	98	4.00
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,360	172	5.00
TOTALS			93,117	11,774	
500.00	Grand Total: Increases		731,174	929,135	500.00

RECLASSIFICATIONS

Provider CCN: 141313

Period:
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Worksheet A-6

Date/Time Prepared:
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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	464,934	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	464,934			
B - EMS SALARY TO ER							
1.00	AMBULANCE SERVICES	95.00	549,752	0	0		1.00
	TOTALS		549,752	0			
C - CLINIC DEPRECIATION							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	452,427	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	452,427			
D - RHC PHYSICIAN							
1.00	RURAL HEALTH CLINIC	88.00	88,305	0	0		1.00
	TOTALS		88,305	0			
E - OP REGISTRATION							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	93,117	11,774	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
	TOTALS		93,117	11,774			
500.00	Grand Total: Decreases		731,174	929,135			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141313

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	3.00	4.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	196,289	0	0	0	1.00
2.00	Land Improvements	559,643	0	0	0	2.00
3.00	Buildings and Fixtures	12,695,167	1,409,505	0	1,409,505	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	2,471,773	98,629	0	98,629	5.00
6.00	Movable Equipment	6,788,907	865,776	0	865,776	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,711,779	2,373,910	0	2,373,910	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,711,779	2,373,910	0	2,373,910	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	826	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,018,587	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,019,413	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0.000000	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	17,431,006	0	0.696386	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,599,669	0	0.303614	0	2.00
3.00	Total (sum of lines 1-2)	25,030,675	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141313

Period:
From 10/01/2010
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Worksheet A-7
Parts I-III
Date/Time Prepared:
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		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	196,289	0			1.00	
2.00	Land Improvements	559,643	0			2.00	
3.00	Buildings and Fixtures	14,104,672	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	2,570,402	0			5.00	
6.00	Movable Equipment	7,599,669	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	25,030,675	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	25,030,675	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	826			1.00	
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0			1.01	
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0			1.02	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,018,587			2.00	
3.00	Total (sum of lines 1-2)	0	1,019,413			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	92,630	-478	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	66,844	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	292,577	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	566,160	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,018,211	-478	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141313

Period:
From 10/01/2010
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Worksheet A-7
Parts I-III
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	146,923	0	0	0	239,075	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	66,844	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	310,440	0	0	0	603,017	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	566,160	2.00
3.00	Total (sum of lines 1-2)	457,363	0	0	0	1,475,096	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141313

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

Worksheet A-8

Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01 Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)			ONEW CAP REL COSTS-CLINIC BUILDING	1.01	1.01
1.02 Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)			ONEW CAP REL COSTS-NEW MED SURG	1.02	1.02
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)		0		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00 Television and radio service (chapter 21)		0		0.00	8.00
9.00 Parking lot (chapter 21)		0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-345,751			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00 Laundry and linen service		0		0.00	13.00
14.00 Cafeteria-employees and guests		0		0.00	14.00
15.00 Rental of quarters to employee and others		0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00 Sale of drugs to other than patients		0		0.00	17.00
18.00 Sale of medical records and abstracts		0		0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00 Vending machines		0		0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01 Depreciation - NEW CAP REL COSTS-CLINIC BUILDING			ONEW CAP REL COSTS-CLINIC BUILDING	1.01	26.01
26.02 Depreciation - NEW CAP REL COSTS-NEW MED SURG			ONEW CAP REL COSTS-NEW MED SURG	1.02	26.02
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00 Physicians' assistant				0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00 MEDICAL RECORD FEES-OTHER OP	B	-6,519	MEDICAL RECORDS & LIBRARY	16.00	33.00
33.01 CAFETERIA SALES - OTHER OP	B	-117,736	DIETARY	10.00	33.01
33.02 SALE OF NON-PAT SUPP - OTHER OP	B	0		0.00	33.02
33.03 PHARMACIST REIMBURSE - OTHER OP	B	3,962	ADMINISTRATIVE & GENERAL	5.01	33.03
33.04 PROF BUILDING RENT - OTHER OP	B	-823	DRUGS CHARGED TO PATIENTS	73.00	33.04
33.05 MISCELLANEOUS -OTHER OP	B	-478	NEW CAP REL COSTS-BLDG & FIXT	1.00	33.05
33.06 COMMUNITY ED FEES - OTHER OP	B	-7,475	ADMINISTRATIVE & GENERAL	5.01	33.06
33.07 LAB OUTREACH REV - OTHER OP	B	-320	ADMINISTRATIVE & GENERAL	5.01	33.07
33.08 HMA MED REC FEES - OTHER OP	B	-57	LABORATORY	60.00	33.08
34.00 MISCELLANEOUS REV - SLEEP LAB	B	-300	MEDICAL RECORDS & LIBRARY	16.00	34.00
	B	-9,377	CARDIOPULMONARY	69.01	35.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141313

Period:
From 10/01/2010
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Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center			Line #
			1.00	2.00		3.00
36.00 INTEREST INCOME - NON OPER	B	-2,432	NEW CAP REL COSTS-BLDG & FIXT	1.00	36.00	
36.01 INTEREST INCOME - NON OPER	B	-5,139	NEW CAP REL COSTS-NEW MED SURG	1.02	36.01	
36.02		0		0.00	36.02	
37.00 TELEPHONE OFFSET - OPERATIONS	A	-310	OPERATION OF PLANT	7.00	37.00	
38.00 TELEPHONE OFFSET - SALARIES	A	-113	ADMINISTRATIVE & GENERAL	5.01	38.00	
39.00 TELEPHONE OFFSET - BENEFITS	A	-27	EMPLOYEE BENEFITS	4.00	39.00	
39.01		0		0.00	39.01	
40.00 MEDI CAR - EXPENSES	A	-17,005	ADMINISTRATIVE & GENERAL	5.01	40.00	
41.00 MEDI CAR BENEFITS	A	-3,075	EMPLOYEE BENEFITS	4.00	41.00	
41.01		0		0.00	41.01	
42.00 LOBBYING DUES	A	-6,546	ADMINISTRATIVE & GENERAL	5.01	42.00	
42.01		0		0.00	42.01	
43.00 ADVERTISING	A	-7,732	ADMINISTRATIVE & GENERAL	5.01	43.00	
43.01		0		0.00	43.01	
43.02 ADVERTISING	A	-982	HOME HEALTH AGENCY	101.00	43.02	
43.03 ADVERTISING	A	-9,246	ADMIN & GENERAL-HOSPITAL	5.02	43.03	
43.04		0		0.00	43.04	
43.05 ADVERTISING	A	-348	RURAL HEALTH CLINIC	88.00	43.05	
43.06 ADVERTISING	A	-595	RURAL HEALTH CLINIC II	88.01	43.06	
43.07 ADVERTISING	A	-114	AMBULANCE SERVICES	95.00	43.07	
43.08		0		0.00	43.08	
44.00 TELEVISIONS	A	-1,202	NEW CAP REL COSTS-NEW MED SURG	1.02	44.00	
45.00		0		0.00	45.00	
45.01		0		0.00	45.01	
45.02 SELF INSURANCE	A	-451,117	EMPLOYEE BENEFITS	4.00	45.02	
45.03 UNFUNDED POST-EMPLOYMENT BENEFIT	A	-57,233	EMPLOYEE BENEFITS	4.00	45.03	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,048,090			50.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 141313

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CLINIC BUILDING	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	MEDICAL RECORD FEES-OTHER OP	0	33.00
33.01	CAFETERIA SALES - OTHER OP	0	33.01
33.02		0	33.02
33.03	SALE OF NON-PAT SUPP - OTHER OP	0	33.03
33.04	PHARMACIST REIMBURSE - OTHER OP	0	33.04
33.05	PROF BUILDING RENT - OTHER OP	10	33.05
33.06	MISCELLANEOUS -OTHER OP	0	33.06
33.07	COMMUNITY ED FEES - OTHER OP	0	33.07
33.08	LAB OUTREACH REV - OTHER OP	0	33.08
34.00	HMA MED REC FEES - OTHER OP	0	34.00
35.00	MISCELLANEOUS REV - SLEEP LAB	0	35.00
36.00	INTEREST INCOME - NON OPER	11	36.00
36.01	INTEREST INCOME - NON OPER	11	36.01
36.02		0	36.02
37.00	TELEPHONE OFFSET - OPERATIONS	0	37.00
38.00	TELEPHONE OFFSET - SALARIES	0	38.00
39.00	TELEPHONE OFFSET - BENEFITS	0	39.00
39.01		0	39.01
40.00	MEDICAR - EXPENSES	0	40.00
41.00	MEDICAR BENEFITS	0	41.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141313

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Wkst. A-7 Ref.	
		5.00	
41.01		0	41.01
42.00	LOBBYING DUES	0	42.00
42.01		0	42.01
43.00	ADVERTISING	0	43.00
43.01		0	43.01
43.02	ADVERTISING	0	43.02
43.03	ADVERTISING	0	43.03
43.04		0	43.04
43.05	ADVERTISING	0	43.05
43.06	ADVERTISING	0	43.06
43.07	ADVERTISING	0	43.07
43.08		0	43.08
44.00	TELEVISIONS	9	44.00
45.00		0	45.00
45.01		0	45.01
45.02	SELF INSURANCE	0	45.02
45.03	UNFUNDED POST-EMPLOYMENT BENEFIT	0	45.03
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: 141313

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

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	EMERGENCY	1,088,640	280,020	1.00
2.00	60.00	LABORATORY	36,000	0	2.00
3.00	69.01	CARDIOPULMONARY	35,969	35,969	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	29,762	29,762	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,190,371	345,751	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141313

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

Worksheet A-8-2

Date/Time Prepared:
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	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	808,620	0	0	0	0	1.00
2.00	36,000	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	844,620					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141313

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

Worksheet A-8-2

Date/Time Prepared:
4/17/2012 9:54 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141313

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

Worksheet A-8-2
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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	280,020	1.00
2.00	0	0	2.00
3.00	0	35,969	3.00
4.00	0	29,762	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	345,751	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW MVBLE EQUIP	
		1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	239,075	239,075				1.00
1.01 NEW CAP REL COSTS-CLINIC BUILDING	66,844	0	66,844			1.01
1.02 NEW CAP REL COSTS-NEW MED SURG	603,017	0	0	603,017		1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	566,160				566,160	2.00
4.00 EMPLOYEE BENEFITS	1,670,595	0	0	0	0	4.00
5.01 ADMINISTRATIVE & GENERAL	1,764,687	32,191	3,546	83,387	30,590	5.01
5.02 ADMIN & GENERAL-HOSPITAL	524,934	1,298	4,367	4,950	4,184	5.02
6.00 MAINTENANCE & REPAIRS	497,197	0	0	0	0	6.00
7.00 OPERATION OF PLANT	230,042	26,955	560	13,199	338	7.00
7.01 OPERATION OF PLANT-CLINIC	17,138	0	0	0	0	7.01
8.00 LAUNDRY & LINEN SERVICE	46,952	7,938	0	4,905	639	8.00
9.00 HOUSEKEEPING	317,115	952	0	2,898	0	9.00
10.00 DIETARY	265,319	12,905	0	0	371	10.00
11.00 CAFETERIA	0	5,486	0	3,344	0	11.00
13.00 NURSING ADMINISTRATION	244,450	4,030	0	7,179	7,083	13.00
14.00 CENTRAL SERVICES & SUPPLY	82,110	6,900	0	0	0	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	213,042	6,514	679	0	2,027	16.00
19.00 NONPHYSICIAN ANESTHETISTS	288,783	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,155,644	3,929	0	470,090	15,955	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	248,935	31,764	0	0	42,381	50.00
53.00 ANESTHESIOLOGY	122	0	0	0	365	53.00
54.00 RADIOLOGY-DIAGNOSTIC	544,096	23,912	0	0	225,867	54.00
54.01 RADIOLOGY-ULTRASOUND	102,181	1,237	0	0	0	54.01
56.00 RADIOISOTOPE	145,272	2,687	0	0	4,902	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	105,104	0	0	0	0	58.00
60.00 LABORATORY	1,135,662	13,775	0	0	29,901	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	46,372	0	0	0	0	62.00
64.00 INTRAVENOUS THERAPY	10,592	0	0	0	0	64.00
66.00 PHYSICAL THERAPY	641,445	7,134	0	0	86,765	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 CARDIOPULMONARY	438,824	24,762	0	0	14,119	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	300,145	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	724,693	3,908	0	0	5,298	73.00
76.00 OP SENIOR HEALTH	413,099	0	2,845	0	0	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	11,714	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	2,720,189	0	49,056	0	55,709	88.00
88.01 RURAL HEALTH CLINIC II	244,194	0	0	0	870	88.01
91.00 EMERGENCY	1,868,259	20,798	0	0	4,288	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	277,493	0	0	0	25,719	95.00
101.00 HOME HEALTH AGENCY	692,413	0	5,791	0	8,175	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	19,463,908	239,075	66,844	589,952	565,546	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,065	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	103,180	0	0	0	614	192.00
194.00 HOSPICE	0	0	0	0	0	194.00
194.01 FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02 MEALS ON WHEELS	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	19,567,088	239,075	66,844	603,017	566,160	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	Subtotal	ADMIN & GENERAL-HOSPITAL	
		4.00	4A	5.01	5A.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	1,670,595					4.00
5.01	ADMINISTRATIVE & GENERAL	135,459	2,049,860	2,049,860			5.01
5.02	ADMIN & GENERAL-HOSPITAL	52,781	592,514	69,336	661,850	661,850	5.02
6.00	MAINTENANCE & REPAIRS	50,730	547,927	64,118	612,045	28,911	6.00
7.00	OPERATION OF PLANT	0	271,094	31,723	302,817	14,304	7.00
7.01	OPERATION OF PLANT-CLINIC	0	17,138	2,005	19,143	904	7.01
8.00	LAUNDRY & LINEN SERVICE	4,403	64,837	7,587	72,424	3,421	8.00
9.00	HOUSEKEEPING	38,856	359,821	42,106	401,927	18,986	9.00
10.00	DIETARY	35,426	314,021	36,747	350,768	16,569	10.00
11.00	CAFETERIA	0	8,830	1,033	9,863	466	11.00
13.00	NURSING ADMINISTRATION	32,625	295,367	34,564	329,931	15,585	13.00
14.00	CENTRAL SERVICES & SUPPLY	11,941	100,951	11,813	112,764	5,327	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	29,200	251,462	29,426	280,888	13,268	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	288,783	33,793	322,576	15,238	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	159,976	1,805,594	211,291	2,016,885	95,272	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	28,967	352,047	41,197	393,244	18,576	50.00
53.00	ANESTHESIOLOGY	0	487	57	544	26	53.00
54.00	RADIOLOGY-DIAGNOSTIC	63,138	857,013	100,288	957,301	45,220	54.00
54.01	RADIOLOGY-ULTRASOUND	10,488	113,906	13,329	127,235	6,010	54.01
56.00	RADIOISOTOPE	7,887	160,748	18,811	179,559	8,482	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	220	105,324	12,325	117,649	5,557	58.00
60.00	LABORATORY	110,706	1,290,044	150,961	1,441,005	68,069	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,372	5,426	51,798	2,447	62.00
64.00	INTRAVENOUS THERAPY	0	10,592	1,239	11,831	559	64.00
66.00	PHYSICAL THERAPY	82,680	818,024	95,725	913,749	43,163	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIOPULMONARY	50,908	528,613	61,858	590,471	27,892	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	300,145	35,123	335,268	15,837	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	43,030	776,929	90,916	867,845	40,994	73.00
76.00	OP SENIOR HEALTH	40,950	456,894	53,466	510,360	24,108	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	11,714	1,371	13,085	618	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	365,455	3,190,409	373,338	3,563,747	0	88.00
88.01	RURAL HEALTH CLINIC II	29,823	274,887	32,167	307,054	0	88.01
91.00	EMERGENCY	148,673	2,042,018	238,957	2,280,975	107,753	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	30,332	333,544	39,031	372,575	17,599	95.00
101.00	HOME HEALTH AGENCY	89,375	795,754	93,119	888,873	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,654,029	19,433,663	2,034,246	19,418,049	661,161	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,065	1,529	14,594	689	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	16,566	120,360	14,085	134,445	0	192.00
194.00	HOSPICE	0	0	0	0	0	194.00
194.01	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,670,595	19,567,088	2,049,860	19,567,088	661,850	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		6.00	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINISTRATIVE & GENERAL						5.01
5.02	ADMIN & GENERAL-HOSPITAL						5.02
6.00	MAINTENANCE & REPAIRS	640,956					6.00
7.00	OPERATION OF PLANT	54,041	371,162				7.00
7.01	OPERATION OF PLANT-CLINIC	0	0	20,047			7.01
8.00	LAUNDRY & LINEN SERVICE	15,694	13,173	0	104,712		8.00
9.00	HOUSEKEEPING	2,379	1,997	0	0	425,289	9.00
10.00	DIETARY	23,847	20,016	0	0	17,829	10.00
11.00	CAFETERIA	10,842	9,100	0	0	8,106	11.00
13.00	NURSING ADMINISTRATION	8,961	7,522	0	0	6,700	13.00
14.00	CENTRAL SERVICES & SUPPLY	12,751	10,702	0	0	9,533	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	13,795	11,579	259	0	10,314	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	106,390	89,297	0	46,104	79,542	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	58,696	49,266	0	13,164	43,884	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	44,187	37,088	0	11,885	33,036	54.00
54.01	RADIOLOGY-ULTRASOUND	2,285	1,918	0	0	1,708	54.01
56.00	RADIOISOTOPE	4,965	4,167	0	0	3,712	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	25,455	21,366	0	84	19,031	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	13,184	11,066	0	3,312	9,857	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIOPULMONARY	45,757	38,406	0	2,131	34,210	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	7,222	6,062	0	0	5,399	73.00
76.00	OP SENIOR HEALTH	7,363	6,180	1,085	0	5,505	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	126,966	0	18,703	792	94,924	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	186	0	88.01
91.00	EMERGENCY	38,432	32,257	0	22,305	28,733	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	4,749	0	95.00
101.00	HOME HEALTH AGENCY	14,989	0	0	0	11,206	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	638,201	371,162	20,047	104,712	423,229	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,755	0	0	0	2,060	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	HOSPICE	0	0	0	0	0	194.00
194.01	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	640,956	371,162	20,047	104,712	425,289	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02 NEW CAP REL COSTS-NEW MED SURG						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMINISTRATIVE & GENERAL						5.01
5.02 ADMIN & GENERAL-HOSPITAL						5.02
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 OPERATION OF PLANT-CLINIC						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	429,029					10.00
11.00 CAFETERIA	311,859	350,236				11.00
13.00 NURSING ADMINISTRATION	0	6,534	375,233			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	6,878	0	157,955		14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	17,338	0	0	0	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	89,415	60,899	214,367	0	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,978	8,999	31,670	433	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	25,535	0	3,919	0	54.00
54.01 RADIOLOGY-ULTRASOUND	0	3,210	0	17	0	54.01
56.00 RADIOISOTOPE	0	1,920	0	17,251	0	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	172	0	1,032	0	58.00
60.00 LABORATORY	0	38,488	0	52,580	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	10,801	0	62.00
64.00 INTRAVENOUS THERAPY	0	0	0	2,467	0	64.00
66.00 PHYSICAL THERAPY	0	25,019	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 CARDIOPULMONARY	0	20,978	0	4,595	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	63,201	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	10,976	0	0	0	73.00
76.00 OP SENIOR HEALTH	24,439	15,934	56,124	13	0	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	85,633	0	0	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00 EMERGENCY	338	20,749	73,072	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	1,646	0	95.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	429,029	349,262	375,233	157,955	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	974	0	0	0	192.00
194.00 HOSPICE	0	0	0	0	0	194.00
194.01 FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02 MEALS ON WHEELS	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	429,029	350,236	375,233	157,955	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141313

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

Worksheet B
Part I
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINISTRATIVE & GENERAL						5.01
5.02	ADMIN & GENERAL-HOSPITAL						5.02
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT-CLINIC						7.01
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	347,441					16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	337,814				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	22,047	0	2,820,218	0	2,820,218	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	9,428	0	630,338	0	630,338	50.00
53.00	ANESTHESIOLOGY	6,349	337,814	344,733	0	344,733	53.00
54.00	RADIOLOGY-DIAGNOSTIC	51,998	0	1,210,169	0	1,210,169	54.00
54.01	RADIOLOGY-ULTRASOUND	4,789	0	147,172	0	147,172	54.01
56.00	RADIOISOTOPE	7,675	0	227,731	0	227,731	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	11,875	0	136,285	0	136,285	58.00
60.00	LABORATORY	67,247	0	1,733,325	0	1,733,325	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	897	0	65,943	0	65,943	62.00
64.00	INTRAVENOUS THERAPY	2,901	0	17,758	0	17,758	64.00
66.00	PHYSICAL THERAPY	18,548	0	1,037,898	0	1,037,898	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIOPULMONARY	19,239	0	783,679	0	783,679	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,455	0	422,761	0	422,761	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	14,215	0	952,713	0	952,713	73.00
76.00	OP SENIOR HEALTH	12,733	0	663,844	0	663,844	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	436	0	14,139	0	14,139	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	32,663	0	3,923,428	0	3,923,428	88.00
88.01	RURAL HEALTH CLINIC II	3,025	0	310,265	0	310,265	88.01
91.00	EMERGENCY	20,345	0	2,624,959	0	2,624,959	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	14,678	0	411,247	0	411,247	95.00
101.00	HOME HEALTH AGENCY	17,898	0	932,966	0	932,966	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	347,441	337,814	19,411,571	0	19,411,571	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	20,098	0	20,098	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	135,419	0	135,419	192.00
194.00	HOSPICE	0	0	0	0	0	194.00
194.01	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	347,441	337,814	19,567,088	0	19,567,088	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141313

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

Worksheet B
Part II
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	NEW MVBLE EQUIP		
		1.00	1.01	1.02	2.00		
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	NEW CAP REL COSTS-CLINIC BUILDING					1.01	
1.02	NEW CAP REL COSTS-NEW MED SURG					1.02	
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00	
5.01	ADMINISTRATIVE & GENERAL	0	32,191	3,546	83,387	30,590	5.01
5.02	ADMIN & GENERAL-HOSPITAL	0	1,298	4,367	4,950	4,184	5.02
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	26,955	560	13,199	338	7.00
7.01	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	0	7,938	0	4,905	639	8.00
9.00	HOUSEKEEPING	0	952	0	2,898	0	9.00
10.00	DIETARY	0	12,905	0	0	371	10.00
11.00	CAFETERIA	0	5,486	0	3,344	0	11.00
13.00	NURSING ADMINISTRATION	0	4,030	0	7,179	7,083	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	6,900	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	6,514	679	0	2,027	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	3,929	0	470,090	15,955	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	31,764	0	0	42,381	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	365	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	23,912	0	0	225,867	54.00
54.01	RADIOLOGY-ULTRASOUND	0	1,237	0	0	0	54.01
56.00	RADIOISOTOPE	0	2,687	0	0	4,902	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	0	13,775	0	0	29,901	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	7,134	0	0	86,765	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIOPULMONARY	0	24,762	0	0	14,119	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,908	0	0	5,298	73.00
76.00	OP SENIOR HEALTH	0	0	2,845	0	0	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	49,056	0	55,709	88.00
88.01	RURAL HEALTH CLINIC II	0	0	0	0	870	88.01
91.00	EMERGENCY	0	20,798	0	0	4,288	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	0	25,719	95.00
101.00	HOME HEALTH AGENCY	0	0	5,791	0	8,175	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	239,075	66,844	589,952	565,546	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,065	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	614	192.00
194.00	HOSPICE	0	0	0	0	0	194.00
194.01	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	239,075	66,844	603,017	566,160	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141313

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

Worksheet B
Part II
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL-HOSPITAL	MAINTENANCE & REPAIRS	
		2A	4.00	5.01	5.02	6.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	0				4.00
5.01	ADMINISTRATIVE & GENERAL	149,714	0	149,714			5.01
5.02	ADMIN & GENERAL-HOSPITAL	14,799	0	5,064	19,863		5.02
6.00	MAINTENANCE & REPAIRS	0	0	4,683	868	5,551	6.00
7.00	OPERATION OF PLANT	41,052	0	2,317	429	468	7.00
7.01	OPERATION OF PLANT-CLINIC	0	0	146	27	0	7.01
8.00	LAUNDRY & LINEN SERVICE	13,482	0	554	103	136	8.00
9.00	HOUSEKEEPING	3,850	0	3,075	570	21	9.00
10.00	DIETARY	13,276	0	2,684	497	207	10.00
11.00	CAFETERIA	8,830	0	75	14	94	11.00
13.00	NURSING ADMINISTRATION	18,292	0	2,525	468	78	13.00
14.00	CENTRAL SERVICES & SUPPLY	6,900	0	863	160	110	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	9,220	0	2,149	398	119	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	2,468	457	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	489,974	0	15,432	2,860	921	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	74,145	0	3,009	558	508	50.00
53.00	ANESTHESIOLOGY	365	0	4	1	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	249,779	0	7,325	1,357	383	54.00
54.01	RADIOLOGY-ULTRASOUND	1,237	0	974	180	20	54.01
56.00	RADIOISOTOPE	7,589	0	1,374	255	43	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	900	167	0	58.00
60.00	LABORATORY	43,676	0	11,026	2,043	220	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	396	73	0	62.00
64.00	INTRAVENOUS THERAPY	0	0	91	17	0	64.00
66.00	PHYSICAL THERAPY	93,899	0	6,992	1,296	114	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIOPULMONARY	38,881	0	4,518	837	396	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,565	475	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	9,206	0	6,640	1,231	63	73.00
76.00	OP SENIOR HEALTH	2,845	0	3,905	724	64	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	100	19	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	104,765	0	27,265	0	1,099	88.00
88.01	RURAL HEALTH CLINIC II	870	0	2,349	0	0	88.01
91.00	EMERGENCY	25,086	0	17,453	3,230	333	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	25,719	0	2,851	528	0	95.00
101.00	HOME HEALTH AGENCY	13,966	0	6,801	0	130	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,461,417	0	148,573	19,842	5,527	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,065	0	112	21	24	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	614	0	1,029	0	0	192.00
194.00	HOSPICE	0	0	0	0	0	194.00
194.01	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,475,096	0	149,714	19,863	5,551	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141313

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

Worksheet B
Part II
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINISTRATIVE & GENERAL						5.01
5.02	ADMIN & GENERAL-HOSPITAL						5.02
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT	44,266					7.00
7.01	OPERATION OF PLANT-CLINIC	0	173				7.01
8.00	LAUNDRY & LINEN SERVICE	1,571	0	15,846			8.00
9.00	HOUSEKEEPING	238	0	0	7,754		9.00
10.00	DIETARY	2,387	0	0	325	19,376	10.00
11.00	CAFETERIA	1,085	0	0	148	14,084	11.00
13.00	NURSING ADMINISTRATION	897	0	0	122	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,276	0	0	174	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,381	2	0	188	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,651	0	6,978	1,450	4,038	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	5,876	0	1,992	800	135	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,423	0	1,798	602	0	54.00
54.01	RADIOLOGY-ULTRASOUND	229	0	0	31	0	54.01
56.00	RADIOISOTOPE	497	0	0	68	0	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	2,548	0	13	347	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	1,320	0	501	180	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIOPULMONARY	4,580	0	322	624	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	723	0	0	98	0	73.00
76.00	OP SENIOR HEALTH	737	9	0	100	1,104	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	162	120	1,731	0	88.00
88.01	RURAL HEALTH CLINIC II	0	0	28	0	0	88.01
91.00	EMERGENCY	3,847	0	3,375	524	15	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	719	0	0	95.00
101.00	HOME HEALTH AGENCY	0	0	0	204	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	44,266	173	15,846	7,716	19,376	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	38	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	HOSPICE	0	0	0	0	0	194.00
194.01	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	44,266	173	15,846	7,754	19,376	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141313

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

Worksheet B
Part II
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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 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02 NEW CAP REL COSTS-NEW MED SURG						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMINISTRATION & GENERAL						5.01
5.02 ADMIN & GENERAL-HOSPITAL						5.02
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 OPERATION OF PLANT-CLINIC						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	24,330					11.00
13.00 NURSING ADMINISTRATION	454	22,836				13.00
14.00 CENTRAL SERVICES & SUPPLY	478	0	9,961			14.00
15.00 PHARMACY	0	0	0	0		15.00
16.00 MEDICAL RECORDS & LIBRARY	1,204	0	0	0	14,661	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4,231	13,046	0	0	931	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	625	1,927	27	0	398	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	268	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,774	0	247	0	2,195	54.00
54.01 RADIOLOGY-ULTRASOUND	223	0	1	0	202	54.01
56.00 RADIOISOTOPE	133	0	1,088	0	324	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	12	0	65	0	501	58.00
60.00 LABORATORY	2,674	0	3,316	0	2,834	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	681	0	38	62.00
64.00 INTRAVENOUS THERAPY	0	0	156	0	122	64.00
66.00 PHYSICAL THERAPY	1,738	0	0	0	783	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 CARDIOPULMONARY	1,457	0	290	0	812	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,985	0	357	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	762	0	0	0	600	73.00
76.00 OP SENIOR HEALTH	1,107	3,416	1	0	537	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	18	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	5,949	0	0	0	1,379	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	128	88.01
91.00 EMERGENCY	1,441	4,447	0	0	859	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	104	0	620	95.00
101.00 HOME HEALTH AGENCY	0	0	0	0	755	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	24,262	22,836	9,961	0	14,661	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	68	0	0	0	0	192.00
194.00 HOSPICE	0	0	0	0	0	194.00
194.01 FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02 MEALS ON WHEELS	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	24,330	22,836	9,961	0	14,661	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141313

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 NEW CAP REL COSTS-CLINIC BUILDING					1.01
1.02 NEW CAP REL COSTS-NEW MED SURG					1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.01 ADMINISTRATIVE & GENERAL					5.01
5.02 ADMIN & GENERAL-HOSPITAL					5.02
6.00 MAINTENANCE & REPAIRS					6.00
7.00 OPERATION OF PLANT					7.00
7.01 OPERATION OF PLANT-CLINIC					7.01
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
19.00 NONPHYSICIAN ANESTHETISTS	2,925				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS		550,512	0	550,512	30.00
31.00 INTENSIVE CARE UNIT		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM		90,000	0	90,000	50.00
53.00 ANESTHESIOLOGY		638	0	638	53.00
54.00 RADIOLOGY-DIAGNOSTIC		269,883	0	269,883	54.00
54.01 RADIOLOGY-ULTRASOUND		3,097	0	3,097	54.01
56.00 RADIOISOTOPE		11,371	0	11,371	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)		1,645	0	1,645	58.00
60.00 LABORATORY		68,697	0	68,697	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS		1,188	0	1,188	62.00
64.00 INTRAVENOUS THERAPY		386	0	386	64.00
66.00 PHYSICAL THERAPY		106,823	0	106,823	66.00
69.00 ELECTROCARDIOLOGY		0	0	0	69.00
69.01 CARDIOPULMONARY		52,717	0	52,717	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS		7,382	0	7,382	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS		19,323	0	19,323	73.00
76.00 OP SENIOR HEALTH		14,549	0	14,549	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES		137	0	137	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC		142,470	0	142,470	88.00
88.01 RURAL HEALTH CLINIC II		3,375	0	3,375	88.01
91.00 EMERGENCY		60,610	0	60,610	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		30,541	0	30,541	95.00
101.00 HOME HEALTH AGENCY		21,856	0	21,856	101.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE		0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1,457,200	0	1,457,200	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN		13,260	0	13,260	190.00
192.00 PHYSICIANS' PRIVATE OFFICES		1,711	0	1,711	192.00
194.00 HOSPICE		0	0	0	194.00
194.01 FAMILY MEDICAL CENTER		0	0	0	194.01
194.02 MEALS ON WHEELS		0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS		0	0	0	194.04
200.00 Cross Foot Adjustments	2,925	2,925	0	2,925	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	2,925	1,475,096	0	1,475,096	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

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Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)		
	1.00	1.01	1.02	2.00		
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	46,981				1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398			1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523		1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP				566,160	2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	10,345,920
5.01	ADMINISTRATIVE & GENERAL	6,326	976	1,870	30,590	838,890
5.02	ADMIN & GENERAL-HOSPITAL	255	1,202	111	4,184	326,867
6.00	MAINTENANCE & REPAIRS	0	0	0	0	314,171
7.00	OPERATION OF PLANT	5,297	154	296	338	0
7.01	OPERATION OF PLANT-CLINIC	0	0	0	0	0
8.00	LAUNDRY & LINEN SERVICE	1,560	0	110	639	27,267
9.00	HOUSEKEEPING	187	0	65	0	240,632
10.00	DIETARY	2,536	0	0	371	219,389
11.00	CAFETERIA	1,078	0	75	0	0
13.00	NURSING ADMINISTRATION	792	0	161	7,083	202,044
14.00	CENTRAL SERVICES & SUPPLY	1,356	0	0	0	73,952
15.00	PHARMACY	0	0	0	0	0
16.00	MEDICAL RECORDS & LIBRARY	1,280	187	0	2,027	180,836
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	772	0	10,542	15,955	990,726
31.00	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,242	0	0	42,381	179,392
53.00	ANESTHESIOLOGY	0	0	0	365	0
54.00	RADIOLOGY-DIAGNOSTIC	4,699	0	0	225,867	391,011
54.01	RADIOLOGY-ULTRASOUND	243	0	0	0	64,950
56.00	RADIOISOTOPE	528	0	0	4,902	48,844
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1,360
60.00	LABORATORY	2,707	0	0	29,901	685,598
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	PHYSICAL THERAPY	1,402	0	0	86,765	512,031
69.00	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	CARDIOPULMONARY	4,866	0	0	14,119	315,272
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	768	0	0	5,298	266,480
76.00	OP SENIOR HEALTH	0	783	0	0	253,601
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	13,502	0	55,709	2,263,257
88.01	RURAL HEALTH CLINIC II	0	0	0	870	184,695
91.00	EMERGENCY	4,087	0	0	4,288	920,727
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	25,719	187,842
101.00	HOME HEALTH AGENCY	0	1,594	0	8,175	553,492
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	46,981	18,398	13,230	565,546	10,243,326
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	614	102,594
194.00	HOSPICE	0	0	0	0	0
194.01	FAMILY MEDICAL CENTER	0	0	0	0	0
194.02	MEALS ON WHEELS	0	0	0	0	0
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	239,075	66,844	603,017	566,160	1,670,595
203.00	Unit cost multiplier (Wkst. B, Part I)	5.088759	3.633221	44.591954	1.000000	0.161474
204.00	Cost to be allocated (per Wkst. B, Part II)					0
205.00	Unit cost multiplier (Wkst. B, Part II)					0.000000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	Reconciliation	ADMIN & GENERAL-HOSPITAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	5A.01	5.01	5A.02	5.02	6.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02 NEW CAP REL COSTS-NEW MED SURG						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMINISTRATIVE & GENERAL	-2,049,860	17,517,228				5.01
5.02 ADMIN & GENERAL-HOSPITAL	0	592,514	-661,850	14,011,119		5.02
6.00 MAINTENANCE & REPAIRS	0	547,927	0	612,045	68,162	6.00
7.00 OPERATION OF PLANT	0	271,094	0	302,817	5,747	7.00
7.01 OPERATION OF PLANT-CLINIC	0	17,138	0	19,143	0	7.01
8.00 LAUNDRY & LINEN SERVICE	0	64,837	0	72,424	1,669	8.00
9.00 HOUSEKEEPING	0	359,821	0	401,927	253	9.00
10.00 DIETARY	0	314,021	0	350,768	2,536	10.00
11.00 CAFETERIA	0	8,830	0	9,863	1,153	11.00
13.00 NURSING ADMINISTRATION	0	295,367	0	329,931	953	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	100,951	0	112,764	1,356	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	251,462	0	280,888	1,467	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	288,783	0	322,576	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	1,805,594	0	2,016,885	11,314	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	352,047	0	393,244	6,242	50.00
53.00 ANESTHESIOLOGY	0	487	0	544	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	857,013	0	957,301	4,699	54.00
54.01 RADIOLOGY-ULTRASOUND	0	113,906	0	127,235	243	54.01
56.00 RADIOISOTOPE	0	160,748	0	179,559	528	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	105,324	0	117,649	0	58.00
60.00 LABORATORY	0	1,290,044	0	1,441,005	2,707	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,372	0	51,798	0	62.00
64.00 INTRAVENOUS THERAPY	0	10,592	0	11,831	0	64.00
66.00 PHYSICAL THERAPY	0	818,024	0	913,749	1,402	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 CARDIOPULMONARY	0	528,613	0	590,471	4,866	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	300,145	0	335,268	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	776,929	0	867,845	768	73.00
76.00 OP SENIOR HEALTH	0	456,894	0	510,360	783	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	11,714	0	13,085	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	3,190,409	-3,563,747	0	13,502	88.00
88.01 RURAL HEALTH CLINIC II	0	274,887	-307,054	0	0	88.01
91.00 EMERGENCY	0	2,042,018	0	2,280,975	4,087	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	333,544	0	372,575	0	95.00
101.00 HOME HEALTH AGENCY	0	795,754	-888,873	0	1,594	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-2,049,860	17,383,803	-5,421,524	13,996,525	67,869	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,065	0	14,594	293	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	120,360	-134,445	0	0	192.00
194.00 HOSPICE	0	0	0	0	0	194.00
194.01 FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02 MEALS ON WHEELS	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)		2,049,860		661,850	640,956	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)		0.117020		0.047237	9.403421	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		149,714		19,863	5,551	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.008547		0.001418	0.081438	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02 NEW CAP REL COSTS-NEW MED SURG						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMINISTRATIVE & GENERAL						5.01
5.02 ADMIN & GENERAL-HOSPITAL						5.02
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT	47,026					7.00
7.01 OPERATION OF PLANT-CLINIC	0	14,472				7.01
8.00 LAUNDRY & LINEN SERVICE	1,669	0	63,587			8.00
9.00 HOUSEKEEPING	253	0	0	60,493		9.00
10.00 DIETARY	2,536	0	0	2,536	26,649	10.00
11.00 CAFETERIA	1,153	0	0	1,153	19,371	11.00
13.00 NURSING ADMINISTRATION	953	0	0	953	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,356	0	0	1,356	0	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,467	187	0	1,467	0	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	11,314	0	27,997	11,314	5,554	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	6,242	0	7,994	6,242	185	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	4,699	0	7,217	4,699	0	54.00
54.01 RADIOLOGY-ULTRASOUND	243	0	0	243	0	54.01
56.00 RADIOISOTOPE	528	0	0	528	0	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	2,707	0	51	2,707	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00 PHYSICAL THERAPY	1,402	0	2,011	1,402	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 CARDIOPULMONARY	4,866	0	1,294	4,866	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	768	0	0	768	0	73.00
76.00 OP SENIOR HEALTH	783	783	0	783	1,518	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	13,502	481	13,502	0	88.00
88.01 RURAL HEALTH CLINIC II	0	0	113	0	0	88.01
91.00 EMERGENCY	4,087	0	13,545	4,087	21	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	2,884	0	0	95.00
101.00 HOME HEALTH AGENCY	0	0	0	1,594	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	47,026	14,472	63,587	60,200	26,649	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	293	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 HOSPICE	0	0	0	0	0	194.00
194.01 FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02 MEALS ON WHEELS	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	371,162	20,047	104,712	425,289	429,029	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	7.892698	1.385227	1.646752	7.030384	16.099253	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	44,266	173	15,846	7,754	19,376	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.941309	0.011954	0.249202	0.128180	0.727082	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1

Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITION)	PHARMACY (COSTED REQUISITION)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02 NEW CAP REL COSTS-NEW MED SURG						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMINISTRATIVE & GENERAL						5.01
5.02 ADMIN & GENERAL-HOSPITAL						5.02
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 OPERATION OF PLANT-CLINIC						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	12,221					11.00
13.00 NURSING ADMINISTRATION	228	77,381				13.00
14.00 CENTRAL SERVICES & SUPPLY	240	0	678,181			14.00
15.00 PHARMACY	0	0	0	100		15.00
16.00 MEDICAL RECORDS & LIBRARY	605	0	0	0	29,745,432	16.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,125	44,207	0	0	1,887,547	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	314	6,531	1,857	0	807,220	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	543,593	53.00
54.00 RADIOLOGY-DIAGNOSTIC	891	0	16,826	0	4,451,914	54.00
54.01 RADIOLOGY-ULTRASOUND	112	0	73	0	410,010	54.01
56.00 RADIOISOTOPE	67	0	74,069	0	657,095	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	6	0	4,431	0	1,016,732	58.00
60.00 LABORATORY	1,343	0	225,753	0	5,756,295	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	46,372	0	76,802	62.00
64.00 INTRAVENOUS THERAPY	0	0	10,592	0	248,373	64.00
66.00 PHYSICAL THERAPY	873	0	0	0	1,588,040	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 CARDIOPULMONARY	732	0	19,729	0	1,647,143	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	271,358	0	723,856	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	383	0	0	100	1,217,008	73.00
76.00 OP SENIOR HEALTH	556	11,574	54	0	1,090,121	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	37,356	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	2,988	0	0	0	2,796,466	88.00
88.01 RURAL HEALTH CLINIC II	0	0	0	0	258,967	88.01
91.00 EMERGENCY	724	15,069	0	0	1,741,846	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	7,067	0	1,256,717	95.00
101.00 HOME HEALTH AGENCY	0	0	0	0	1,532,331	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	12,187	77,381	678,181	100	29,745,432	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	34	0	0	0	0	192.00
194.00 HOSPICE	0	0	0	0	0	194.00
194.01 FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02 MEALS ON WHEELS	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	350,236	375,233	157,955	0	347,441	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	28.658539	4.849162	0.232910	0.000000	0.011680	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	24,330	22,836	9,961	0	14,661	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	1.990835	0.295111	0.014688	0.000000	0.000493	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141313

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

Worksheet B-1
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING		1.01
1.02	NEW CAP REL COSTS-NEW MED SURG		1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.01	ADMINISTRATIVE & GENERAL		5.01
5.02	ADMIN & GENERAL-HOSPITAL		5.02
6.00	MAINTENANCE & REPAIRS		6.00
7.00	OPERATION OF PLANT		7.00
7.01	OPERATION OF PLANT-CLINIC		7.01
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
19.00	NONPHYSICIAN ANESTHETISTS	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS		30.00
31.00	INTENSIVE CARE UNIT		31.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0	50.00
53.00	ANESTHESIOLOGY	100	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	RADIOLOGY-ULTRASOUND	0	54.01
56.00	RADIOISOTOPE	0	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	LABORATORY	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
64.00	INTRAVENOUS THERAPY	0	64.00
66.00	PHYSICAL THERAPY	0	66.00
69.00	ELECTROCARDIOLOGY	0	69.00
69.01	CARDIOPULMONARY	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	OP SENIOR HEALTH	0	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	0	88.00
88.01	RURAL HEALTH CLINIC II	0	88.01
91.00	EMERGENCY	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	0	95.00
101.00	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	118.00
NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	HOSPICE	0	194.00
194.01	FAMILY MEDICAL CENTER	0	194.01
194.02	MEALS ON WHEELS	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	194.04
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)	337,814	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3,378.140000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,925	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	29.250000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141313

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

Worksheet C
Part I
Date/Time Prepared:
4/17/2012 9:54 am

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,820,218		2,820,218	0	0 30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0 31.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	630,338		630,338	0	0 50.00
53.00	ANESTHESIOLOGY	344,733		344,733	0	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,210,169		1,210,169	0	0 54.00
54.01	RADIOLOGY-ULTRASOUND	147,172		147,172	0	0 54.01
56.00	RADIOISOTOPE	227,731		227,731	0	0 56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	136,285		136,285	0	0 58.00
60.00	LABORATORY	1,733,325		1,733,325	0	0 60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	65,943		65,943	0	0 62.00
64.00	INTRAVENOUS THERAPY	17,758		17,758	0	0 64.00
66.00	PHYSICAL THERAPY	1,037,898	0	1,037,898	0	0 66.00
69.00	ELECTROCARDIOLOGY	0		0	0	0 69.00
69.01	CARDIOPULMONARY	783,679		783,679	0	0 69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	422,761		422,761	0	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	952,713		952,713	0	0 73.00
76.00	OP SENIOR HEALTH	663,844		663,844	0	0 76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	14,139		14,139	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	3,923,428		3,923,428	0	0 88.00
88.01	RURAL HEALTH CLINIC II	310,265		310,265	0	0 88.01
91.00	EMERGENCY	2,624,959		2,624,959	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	236,657		236,657	0	0 92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	411,247		411,247	0	0 95.00
101.00	HOME HEALTH AGENCY	932,966		932,966	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	19,648,228	0	19,648,228	0	0 200.00
201.00	Less Observation Beds	236,657		236,657		0 201.00
202.00	Total (see instructions)	19,411,571	0	19,411,571	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141313

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIII			Hospital	Cost	
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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,598,593		1,598,593			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	121,371	685,849	807,220	0.780875	0.000000	50.00
53.00	ANESTHESIOLOGY	81,668	461,925	543,593	0.634175	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	261,130	4,190,784	4,451,914	0.271831	0.000000	54.00
54.01	RADIOLOGY-ULTRASOUND	39,048	370,962	410,010	0.358947	0.000000	54.01
56.00	RADIOISOTOPE	9,391	647,704	657,095	0.346572	0.000000	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	26,018	990,714	1,016,732	0.134042	0.000000	58.00
60.00	LABORATORY	599,066	5,157,229	5,756,295	0.301118	0.000000	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	36,681	40,121	76,802	0.858610	0.000000	62.00
64.00	INTRAVENOUS THERAPY	48,591	199,782	248,373	0.071497	0.000000	64.00
66.00	PHYSICAL THERAPY	374,368	1,213,672	1,588,040	0.653572	0.000000	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	CARDIOPULMONARY	384,918	1,262,225	1,647,143	0.475781	0.000000	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	354,692	369,164	723,856	0.584040	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	407,887	809,121	1,217,008	0.782832	0.000000	73.00
76.00	OP SENIOR HEALTH	0	1,090,121	1,090,121	0.608964	0.000000	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	37,356	37,356	0.378493	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	2,796,466	2,796,466			88.00
88.01	RURAL HEALTH CLINIC II	0	258,967	258,967			88.01
91.00	EMERGENCY	24,253	1,717,593	1,741,846	1.506998	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2,200	286,754	288,954	0.819013	0.000000	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	1,256,717	1,256,717	0.327239	0.000000	95.00
101.00	HOME HEALTH AGENCY	0	1,532,331	1,532,331			101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	4,369,875	25,375,557	29,745,432			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	4,369,875	25,375,557	29,745,432			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 4/17/2012 9:54 am
Cost Center Description		PPS Inpatient Ratio 11.00	Title XVIII	Hospital
				Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	RADIOISOTOPE	0.000000		56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	LABORATORY	0.000000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	INTRAVENOUS THERAPY	0.000000		64.00
66.00	PHYSICAL THERAPY	0.000000		66.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
69.01	CARDIOPULMONARY	0.000000		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	OP SENIOR HEALTH	0.000000		76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC			88.00
88.01	RURAL HEALTH CLINIC II			88.01
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0.000000		95.00
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141313

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

Worksheet C
Part I
Date/Time Prepared:
4/17/2012 9:54 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,820,218		2,820,218	0	0	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	630,338		630,338	0	0	50.00
53.00	ANESTHESIOLOGY	344,733		344,733	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,210,169		1,210,169	0	0	54.00
54.01	RADIOLOGY-ULTRASOUND	147,172		147,172	0	0	54.01
56.00	RADIOISOTOPE	227,731		227,731	0	0	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	136,285		136,285	0	0	58.00
60.00	LABORATORY	1,733,325		1,733,325	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	65,943		65,943	0	0	62.00
64.00	INTRAVENOUS THERAPY	17,758		17,758	0	0	64.00
66.00	PHYSICAL THERAPY	1,037,898	0	1,037,898	0	0	66.00
69.00	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	CARDIOPULMONARY	783,679		783,679	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	422,761		422,761	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	952,713		952,713	0	0	73.00
76.00	OP SENIOR HEALTH	663,844		663,844	0	0	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	14,139		14,139	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	3,923,428		3,923,428	0	0	88.00
88.01	RURAL HEALTH CLINIC II	310,265		310,265	0	0	88.01
91.00	EMERGENCY	2,624,959		2,624,959	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	236,657		236,657	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	411,247		411,247	0	0	95.00
101.00	HOME HEALTH AGENCY	932,966		932,966	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	19,648,228	0	19,648,228	0	0	200.00
201.00	Less Observation Beds	236,657		236,657			201.00
202.00	Total (see instructions)	19,411,571	0	19,411,571	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 4/17/2012 9:54 am
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,598,593		1,598,593			30.00
31.00 INTENSIVE CARE UNIT	0		0			31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	121,371	685,849	807,220	0.780875	0.000000	50.00
53.00 ANESTHESIOLOGY	81,668	461,925	543,593	0.634175	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	261,130	4,190,784	4,451,914	0.271831	0.000000	54.00
54.01 RADIOLOGY-ULTRASOUND	39,048	370,962	410,010	0.358947	0.000000	54.01
56.00 RADIOISOTOPE	9,391	647,704	657,095	0.346572	0.000000	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	26,018	990,714	1,016,732	0.134042	0.000000	58.00
60.00 LABORATORY	599,066	5,157,229	5,756,295	0.301118	0.000000	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	36,681	40,121	76,802	0.858610	0.000000	62.00
64.00 INTRAVENOUS THERAPY	48,591	199,782	248,373	0.071497	0.000000	64.00
66.00 PHYSICAL THERAPY	374,368	1,213,672	1,588,040	0.653572	0.000000	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01 CARDIOPULMONARY	384,918	1,262,225	1,647,143	0.475781	0.000000	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	354,692	369,164	723,856	0.584040	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	407,887	809,121	1,217,008	0.782832	0.000000	73.00
76.00 OP SENIOR HEALTH	0	1,090,121	1,090,121	0.608964	0.000000	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	37,356	37,356	0.378493	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	2,796,466	2,796,466	1.402995	0.000000	88.00
88.01 RURAL HEALTH CLINIC II	0	258,967	258,967	1.198087	0.000000	88.01
91.00 EMERGENCY	24,253	1,717,593	1,741,846	1.506998	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	2,200	286,754	288,954	0.819013	0.000000	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	1,256,717	1,256,717	0.327239	0.000000	95.00
101.00 HOME HEALTH AGENCY	0	1,532,331	1,532,331			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	4,369,875	25,375,557	29,745,432			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	4,369,875	25,375,557	29,745,432			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 4/17/2012 9:54 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	RADIOISOTOPE	0.000000		56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	LABORATORY	0.000000		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	INTRAVENOUS THERAPY	0.000000		64.00
66.00	PHYSICAL THERAPY	0.000000		66.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
69.01	CARDIOPULMONARY	0.000000		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	OP SENIOR HEALTH	0.000000		76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		88.00
88.01	RURAL HEALTH CLINIC II	0.000000		88.01
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0.000000		95.00
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 4/17/2012 9:54 am
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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)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	90,000	807,220	0.111494	64,704	7,214	50.00
53.00	ANESTHESIOLOGY	638	543,593	0.001174	46,184	54	53.00
54.00	RADIOLOGY-DIAGNOSTIC	269,883	4,451,914	0.060622	122,025	7,397	54.00
54.01	RADIOLOGY-ULTRASOUND	3,097	410,010	0.007553	24,364	184	54.01
56.00	RADIOISOTOPE	11,371	657,095	0.017305	7,938	137	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	1,645	1,016,732	0.001618	19,785	32	58.00
60.00	LABORATORY	68,697	5,756,295	0.011934	356,468	4,254	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,188	76,802	0.015468	26,709	413	62.00
64.00	INTRAVENOUS THERAPY	386	248,373	0.001554	22,058	34	64.00
66.00	PHYSICAL THERAPY	106,823	1,588,040	0.067267	108,986	7,331	66.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	CARDIOPULMONARY	52,717	1,647,143	0.032005	195,967	6,272	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,382	723,856	0.010198	214,325	2,186	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	19,323	1,217,008	0.015877	190,733	3,028	73.00
76.00	OP SENIOR HEALTH	14,549	1,090,121	0.013346	0	0	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	137	37,356	0.003667	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	142,470	2,796,466	0.050946	0	0	88.00
88.01	RURAL HEALTH CLINIC II	3,375	258,967	0.013033	0	0	88.01
91.00	EMERGENCY	60,610	1,741,846	0.034796	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	288,954	0.000000	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	854,291	25,357,791		1,400,246	38,536	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313

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

Worksheet D
Part IV
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	337,814	0	0	0	337,814	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	0	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OP SENIOR HEALTH	0	0	0	0	0	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
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
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	337,814	0	0	0	337,814	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313

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

Worksheet D
Part IV
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description		Title XVIII			Hospital		Cost
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	807,220	0.000000	0.000000	64,704	50.00
53.00	ANESTHESIOLOGY	0	543,593	0.621447	0.000000	46,184	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	4,451,914	0.000000	0.000000	122,025	54.00
54.01	RADIOLOGY-ULTRASOUND	0	410,010	0.000000	0.000000	24,364	54.01
56.00	RADIOISOTOPE	0	657,095	0.000000	0.000000	7,938	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	1,016,732	0.000000	0.000000	19,785	58.00
60.00	LABORATORY	0	5,756,295	0.000000	0.000000	356,468	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	76,802	0.000000	0.000000	26,709	62.00
64.00	INTRAVENOUS THERAPY	0	248,373	0.000000	0.000000	22,058	64.00
66.00	PHYSICAL THERAPY	0	1,588,040	0.000000	0.000000	108,986	66.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	CARDIOPULMONARY	0	1,647,143	0.000000	0.000000	195,967	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	723,856	0.000000	0.000000	214,325	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,217,008	0.000000	0.000000	190,733	73.00
76.00	OP SENIOR HEALTH	0	1,090,121	0.000000	0.000000	0	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	37,356	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	2,796,466	0.000000	0.000000	0	88.00
88.01	RURAL HEALTH CLINIC II	0	258,967	0.000000	0.000000	0	88.01
91.00	EMERGENCY	0	1,741,846	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	288,954	0.000000	0.000000	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	25,357,791			1,400,246	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313

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

Worksheet D
Part IV
Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description		Title XVIII			Hospital	Cost	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	28,701	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	0	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	OP SENIOR HEALTH	0	0	0	0	0	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
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
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	28,701	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 4/17/2012 9:54 am
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Cost Center Description	PSA Adj .	PSA Adj . All	Hospital	Cost
	Allied Health	Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0		50.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 RADIOLOGY-ULTRASOUND	0	0		54.01
56.00 RADIOISOTOPE	0	0		56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 LABORATORY	0	0		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00 INTRAVENOUS THERAPY	0	0		64.00
66.00 PHYSICAL THERAPY	0	0		66.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
69.01 CARDIOPULMONARY	0	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 OP SENIOR HEALTH	0	0		76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	0		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0		88.00
88.01 RURAL HEALTH CLINIC II	0	0		88.01
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 4/17/2012 9:54 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
			1.00	2.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.780875	0	257,728	0	50.00
53.00 ANESTHESIOLOGY	0.634175	0	185,209	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.271831	0	1,850,176	0	54.00
54.01 RADIOLOGY-ULTRASOUND	0.358947	0	154,016	0	54.01
56.00 RADIOISOTOPE	0.346572	0	339,300	0	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.134042	0	298,920	0	58.00
60.00 LABORATORY	0.301118	0	2,774,211	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.858610	0	29,201	0	62.00
64.00 INTRAVENOUS THERAPY	0.071497	0	98,427	0	64.00
66.00 PHYSICAL THERAPY	0.653572	0	508,115	0	66.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01 CARDIOPULMONARY	0.475781	0	709,331	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.584040	0	151,439	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.782832	0	480,525	0	73.00
76.00 OP SENIOR HEALTH	0.608964	0	1,083,034	0	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0.378493	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
88.01 RURAL HEALTH CLINIC II	0.000000				88.01
91.00 EMERGENCY	1.506998	0	484,099	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.819013	0	177,629	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0.327239		0		95.00
200.00 Subtotal (see instructions)		0	9,581,360	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	9,581,360	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 4/17/2012 9:54 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	
	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	201,253	0	50.00
53.00 ANESTHESIOLOGY	0	117,455	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	502,935	0	54.00
54.01 RADIOLOGY-ULTRASOUND	0	55,284	0	54.01
56.00 RADIOISOTOPE	0	117,592	0	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	40,068	0	58.00
60.00 LABORATORY	0	835,365	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	25,072	0	62.00
64.00 INTRAVENOUS THERAPY	0	7,037	0	64.00
66.00 PHYSICAL THERAPY	0	332,090	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
69.01 CARDIOPULMONARY	0	337,486	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	88,446	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	376,170	0	73.00
76.00 OP SENIOR HEALTH	0	659,529	0	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	76.01
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
91.00 EMERGENCY	0	729,536	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	145,480	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES		0		95.00
200.00 Subtotal (see instructions)	0	4,570,798	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	4,570,798	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141313 Component CCN: 14Z313	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 4/17/2012 9:54 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.780875	0	0	0	50.00
53.00 ANESTHESIOLOGY	0.634175	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.271831	0	0	0	54.00
54.01 RADIOLOGY-ULTRASOUND	0.358947	0	0	0	54.01
56.00 RADIOISOTOPE	0.346572	0	0	0	56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.134042	0	0	0	58.00
60.00 LABORATORY	0.301118	0	0	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.858610	0	0	0	62.00
64.00 INTRAVENOUS THERAPY	0.071497	0	0	0	64.00
66.00 PHYSICAL THERAPY	0.653572	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01 CARDIOPULMONARY	0.475781	0	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.584040	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.782832	0	0	0	73.00
76.00 OP SENIOR HEALTH	0.608964	0	0	0	76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0.378493	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
88.01 RURAL HEALTH CLINIC II	0.000000				88.01
91.00 EMERGENCY	1.506998	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.819013	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0.327239		0		95.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141313 Component CCN: 14Z313	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 4/17/2012 9:54 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01 RADIOLOGY-ULTRASOUND	0	0	0		54.01
56.00 RADIOISOTOPE	0	0	0		56.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00 LABORATORY	0	0	0		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
69.01 CARDIOPULMONARY	0	0	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00 OP SENIOR HEALTH	0	0	0		76.00
76.01 TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0		76.01
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
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 4/17/2012 9:54 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,650 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,010 2.00
3.00	Private room days (excluding swing-bed and observation bed days)			25 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			985 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			136 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)			409 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			24 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)			71 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			672 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)			136 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)			387 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)			14 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			116.26 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			116.26 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,820,218 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			2,790 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)			8,254 25.00
26.00	Total swing-bed cost (see instructions)			995,608 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,824,610 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			1,003,532 28.00
29.00	Private room charges (excluding swing-bed charges)			35,622 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			967,910 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.818188 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			1,424.88 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			982.65 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			442.23 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			804.06 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			20,102 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,804,508 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,786.64 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,200,622 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			11,257 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,211,879 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141313		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 4/17/2012 9:54 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					697,935		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,909,814		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					242,983		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					691,430		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					934,413		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)						131	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,806.54	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						236,657	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141313		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 4/17/2012 9:54 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 4/17/2012 9:54 am
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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		861,615		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.780875	64,704	50,526	50.00
53.00	ANESTHESIOLOGY	0.634175	46,184	29,289	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.271831	122,025	33,170	54.00
54.01	RADIOLOGY-ULTRASOUND	0.358947	24,364	8,745	54.01
56.00	RADIOISOTOPE	0.346572	7,938	2,751	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.134042	19,785	2,652	58.00
60.00	LABORATORY	0.301118	356,468	107,339	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.858610	26,709	22,933	62.00
64.00	INTRAVENOUS THERAPY	0.071497	22,058	1,577	64.00
66.00	PHYSICAL THERAPY	0.653572	108,986	71,230	66.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	CARDIOPULMONARY	0.475781	195,967	93,237	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.584040	214,325	125,174	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.782832	190,733	149,312	73.00
76.00	OP SENIOR HEALTH	0.608964	0	0	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0.378493	0	0	76.01
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
91.00	EMERGENCY	1.506998	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.819013	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,400,246	697,935	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,400,246		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN: 14Z313		Date/Time Prepared: 4/17/2012 9:54 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		438,815		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.780875	0	0	50.00
53.00	ANESTHESIOLOGY	0.634175	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.271831	40,204	10,929	54.00
54.01	RADIOLOGY-ULTRASOUND	0.358947	4,629	1,662	54.01
56.00	RADIOISOTOPE	0.346572	1,453	504	56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.134042	6,233	835	58.00
60.00	LABORATORY	0.301118	105,031	31,627	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.858610	6,705	5,757	62.00
64.00	INTRAVENOUS THERAPY	0.071497	10,503	751	64.00
66.00	PHYSICAL THERAPY	0.653572	216,689	141,622	66.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	CARDIOPULMONARY	0.475781	127,352	60,592	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.584040	53,434	31,208	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.782832	134,238	105,086	73.00
76.00	OP SENIOR HEALTH	0.608964	0	0	76.00
76.01	TELEMEDICINE-PSYCHIATRIC SERVICES	0.378493	0	0	76.01
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
91.00	EMERGENCY	1.506998	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.819013	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		706,471	390,573	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		706,471		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/17/2012 9:54 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,570,798 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)			4,570,798 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)			4,616,506 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)			43,735 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,353,812 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)			3,218,959 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)			3,218,959 30.00
31.00	Primary payer payments			1,584 31.00
32.00	Subtotal (line 30 minus line 31)			3,217,375 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)			301,636 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			301,636 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			270,379 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,519,011 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)			3,519,011 40.00
41.00	Interim payments			3,723,778 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)			-204,767 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: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 4/17/2012 9:54 am
		Title XVIII	Hospital
			Cost
			Overrides
			1.00
112.00	WORKSHEET OVERRIDE VALUES Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141313

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

Worksheet E-1
Part I
Date/Time Prepared:
4/17/2012 9:54 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,451,494		3,723,778	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)		1,451,494		3,723,778	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		318,055		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		204,767	6.02	
7.00	Total Medicare program liability (see instructions)		1,769,549		3,519,011	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: 141313

Period: From 10/01/2010

Worksheet E-1

Component CCN: 14Z313

To 09/30/2011

Part I
Date/Time Prepared:
4/17/2012 9:54 am

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,058,862		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	04/21/2011	12,900		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)		12,900		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,071,762		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		255,985		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,327,747		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet E-2
		Component CCN: 14Z313	Date/Time Prepared: 4/17/2012 9:54 am	
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	943,757	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	394,479	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	523	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,338,236	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,338,236	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,338,236	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	10,489	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,327,747	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,327,747	0	19.00
20.00	Interim payments	1,071,762	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	255,985	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part V Date/Time Prepared: 4/17/2012 9:54 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		1,909,814	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		1,909,814	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		1,928,912	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,928,912	19.00
20.00	Deductibles (exclude professional component)		202,256	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		1,726,656	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,726,656	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		42,893	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		42,893	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		38,476	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		1,769,549	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		1,769,549	30.00
31.00	Interim payments		1,451,494	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		318,055	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 4/17/2012 9:54 am
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		0	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	12.00
CUSTOMARY CHRGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 141313

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

Worksheet G

Date/Time Prepared:
4/17/2012 9:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,323,018	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,069,022	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	339,859	0	0	0	7.00
8.00	Prepaid expenses	110,572	0	0	0	8.00
9.00	Other current assets	456,228	0	0	0	9.00
10.00	Due from other funds	104,287	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,402,986	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	10,096,354	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,585,838	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,682,192	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,734,595	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,734,595	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,819,773	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	998,891	0	0	0	37.00
38.00	Salaries, wages, and fees payable	357,368	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	681,115	0	0	0	40.00
41.00	Deferred income	686,782	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	1,118,934	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,843,090	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,698,633	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	367,382	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,066,015	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,909,105	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	7,910,668	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)	7,910,668	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,819,773	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141313

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

Worksheet G-1

Date/Time Prepared:
4/17/2012 9:54 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		7,368,440	
2.00	Net income (loss) (From Wkst. G-3, line 29)		542,228			2.00
3.00	Total (sum of line 1 and line 2)		7,910,668		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)		7,910,668		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)		7,910,668		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141313

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

Worksheet G-1

Date/Time Prepared:
4/17/2012 9:54 am

	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: 141313

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

Worksheet G-2 Parts

Date/Time Prepared:
4/17/2012 9:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,890,630		1,890,630	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,890,630		1,890,630	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,890,630		1,890,630	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,796,466	2,796,466	20.00
20.01	RURAL HEALTH CLINIC II	0	258,967	258,967	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,532,331	1,532,331	22.00
23.00	AMBULANCE SERVICES	0	1,259,657	1,259,657	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OPERATING ROOM	194,342	811,916	1,006,258	27.00
27.01	ANESTHESIOLOGY	92,253	535,998	628,251	27.01
27.02	RADIOLOGY-DIAGNOSTIC	302,669	6,038,744	6,341,413	27.02
27.03	RADIOLOGY-ULTRASOUND	39,048	381,282	420,330	27.03
27.04	LABORATORY	637,638	5,323,891	5,961,529	27.04
27.05	INTRAVENOUS THERAPY	97,171	234,941	332,112	27.05
27.06	PHYSICAL THERAPY	376,485	1,228,825	1,605,310	27.06
27.07	CARDIOPULMONARY	560,956	1,447,324	2,008,280	27.07
27.08	MEDICAL SUPPLIES CHARGED	53,750	149,421	203,171	27.08
27.09	DRUGS CHARGED TO PATIENTS	407,969	830,654	1,238,623	27.09
27.10	OP SENIOR PSYCH	0	1,090,121	1,090,121	27.10
27.11	TELEMEDICINE PSYCH	0	37,356	37,356	27.11
27.12	EMERGENCY	59,286	3,522,494	3,581,780	27.12
27.13	SLEEP MANAGEMENT	0	9,377	9,377	27.13
27.14		0	0	0	27.14
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,712,197	27,489,765	32,201,962	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,615,178		29.00
30.00	GASB EXPENSE	57,233			30.00
31.00	IMRF EXPENSE	61,417			31.00
32.00	ROUND	6			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)		118,656		36.00
37.00	EMPLOYEE PHYSICALS	2,677			37.00
38.00	PHARMICIST REIMBURSE	823			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)		3,500		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,730,334		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141313

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

Worksheet G-3

Date/Time Prepared:
4/17/2012 9:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	32,201,962	1.00
2.00	Less contractual allowances and discounts on patients' accounts	10,656,995	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,544,967	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,730,334	4.00
5.00	Net income from service to patients (line 3 minus line 4)	814,633	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	470,279	6.00
7.00	Income from investments	10,251	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	839,377	23.00
24.00	GRANT REVENUE	54,880	24.00
24.01	OTHER OPERATING REVENUE	507,876	24.01
24.02		61	24.02
25.00	Total other income (sum of lines 6-24)	1,882,724	25.00
26.00	Total (line 5 plus line 25)	2,697,357	26.00
27.00	PROVISION FOR DOUBTFUL ACCOUNTS	1,554,199	27.00
27.01	CHARITY CARE	600,930	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	2,155,129	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	542,228	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141313

Period: From 10/01/2010

Worksheet H

HHA CCN: 147202

To 09/30/2011

Date/Time Prepared: 4/17/2012 9:54 am

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	111,783	7,954	38,977	0	61,543	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	424,526	30,206	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	352	25	0	0	0	10.00
11.00	Home Health Aide	16,831	1,198	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 (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	553,492	39,383	38,977	0	61,543	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: 141313

Period: From 10/01/2010

Worksheet H

HHA CCN: 147202

To 09/30/2011

Date/Time Prepared: 4/17/2012 9:54 am

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	220,257	0	220,257	0	220,257	5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	454,732	0	454,732	0	454,732	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	377	0	377	0	377	10.00
11.00 Home Health Aide	18,029	0	18,029	0	18,029	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 (specify)	0	0	0	-982	-982	23.00
24.00 Total (sum of lines 1-23)	693,395	0	693,395	-982	692,413	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: 141313	Period: From 10/01/2010	Worksheet H-1 Part I Date/Time Prepared: 4/17/2012 9:54 am
	HHA CCN: 147202	To 09/30/2011	
		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	220,257	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	454,732	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 Pathology	0	0	0	0	9.00
10.00	Medical Social Services	377	0	0	0	10.00
11.00	Home Health Aide	18,029	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 (specify)	-982	0	0	0	23.00
24.00	Total (sum of lines 1-23)	692,413	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet H-1 Part I Date/Time Prepared: 4/17/2012 9:54 am
		HHA CCN: 147202	Home Health Agency I	PPS

		Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)	
		4A.00	5.00	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 Operation & Maintenance	0			3.00
4.00	Transportation				4.00
5.00	Administrative and General	220,257	220,257		5.00
HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	454,732	212,129	666,861	6.00
7.00	Physical Therapy	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	8.00
9.00	Speech Pathology	0	0	0	9.00
10.00	Medical Social Services	377	176	553	10.00
11.00	Home Health Aide	18,029	8,410	26,439	11.00
12.00	Supplies (see instructions)	0	0	0	12.00
13.00	Drugs	0	0	0	13.00
14.00	DME	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	17.00
18.00	Clinic	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	19.00
20.00	Day Care Program	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	21.00
22.00	Homemaker Service	0	0	0	22.00
23.00	All Others (specify)	-982	-458	-1,440	23.00
24.00	Total (sum of lines 1-23)	472,156		692,413	24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 141313 HHA CCN: 147202		Period: From 10/01/2010 To 09/30/2011		Worksheet H-1 Part II Date/Time Prepared: 4/17/2012 9:54 am	
				Home Health Agency I		PPS	
		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.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	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-220,257	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 (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-220,257	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: 141313	Period: From 10/01/2010	Worksheet H-1 Part II Date/Time Prepared: 4/17/2012 9:54 am
	HHA CCN: 147202	To 09/30/2011	
		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	472,156	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	454,732	6.00
7.00	Physical Therapy	0	7.00
8.00	Occupational Therapy	0	8.00
9.00	Speech Pathology	0	9.00
10.00	Medical Social Services	377	10.00
11.00	Home Health Aide	18,029	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 (specify)	-982	23.00
24.00	Total (sum of lines 1-23)	472,156	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	220,257	25.00
26.00	Unit Cost Multiplier	0.466492	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313

Period:

Worksheet H-2

HHA CCN: 147202

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

Part I
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		CAPITAL RELATED COSTS					
		HHA Trial Balance (1)	NEW BLDG & FIXT 1.00	NEW CLINIC BUILDING 1.01	NEW NEW MED SURG 1.02	NEW MVBLE EQUIP 2.00	
1.00	Administrative and General	0	0	5,791	0	8,175	1.00
2.00	Skilled Nursing Care	666,861	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	553	0	0	0	0	6.00
7.00	Home Health Aide	26,439	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 (specify)	-1,440	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	692,413	0	5,791	0	8,175	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: 141313

Period: From 10/01/2010

Worksheet H-2

HHA CCN: 147202

To 09/30/2011

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	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	Subtotal	ADMIN & GENERAL-HOSPITAL	
	4.00	4A	5.01	5A.01	5.02	
1.00 Administrative and General	89,375	103,341	12,093	115,434	0	1.00
2.00 Skilled Nursing Care	0	666,861	78,036	744,897	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	553	65	618	0	6.00
7.00 Home Health Aide	0	26,439	3,094	29,533	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 (specify)	0	-1,440	-169	-1,609	0	19.00
20.00 Total (sum of lines 1-19) (2)	89,375	795,754	93,119	888,873	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.		0.000000		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: 141313	Period: From 10/01/2010	Worksheet H-2
		HHA CCN: 147202	To 09/30/2011	Part I
				Date/Time Prepared: 4/17/2012 9:54 am
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	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	6.00	7.00	7.01	8.00	9.00	
1.00 Administrative and General	14,989	0	0	0	11,206	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 (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	14,989	0	0	0	11,206	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: 141313

Period:

Worksheet H-2

HHA CCN: 147202

From 10/01/2010
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	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
1.00 Administrative and General	0	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 (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	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: 141313	Period: From 10/01/2010	Worksheet H-2 Part I
		HHA CCN: 147202	To 09/30/2011	Date/Time Prepared: 4/17/2012 9:54 am
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	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
	16.00	19.00	24.00	25.00	26.00	
1.00 Administrative and General	17,898	0	159,527	0	159,527	1.00
2.00 Skilled Nursing Care	0	0	744,897	0	744,897	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	618	0	618	6.00
7.00 Home Health Aide	0	0	29,533	0	29,533	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 (specify)	0	0	-1,609	0	-1,609	19.00
20.00 Total (sum of lines 1-19) (2)	17,898	0	932,966	0	932,966	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: 141313	Period: From 10/01/2010	Worksheet H-2
		HHA CCN: 147202	To 09/30/2011	Part I
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		Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	153,641	898,538	2.00
3.00	Physical Therapy	0	0	3.00
4.00	Occupational Therapy	0	0	4.00
5.00	Speech Pathology	0	0	5.00
6.00	Medical Social Services	127	745	6.00
7.00	Home Health Aide	6,091	35,624	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	-332	-1,941	19.00
20.00	Total (sum of lines 1-19) (2)	159,527	932,966	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.	0.206257		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: 141313
HHA CCN: 147202

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

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		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	1.02	2.00		
1.00	Administrative and General	0	1,594	0	8,175	553,492	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 (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1,594	0	8,175	553,492	20.00
21.00	Total cost to be allocated	0	5,791	0	8,175	89,375	21.00
22.00	Unit cost multiplier	0.000000	3.632999	0.000000	1.000000	0.161475	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141313
HHA CCN: 147202

Period:
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Part II
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		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	Reconciliation	ADMIN & GENERAL-HOSPITAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5A.01	5.01	5A.02	5.02	6.00	
1.00	Administrative and General	0	103,341	-115,434	0	1,594	1.00
2.00	Skilled Nursing Care	0	666,861	-744,897	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	553	-618	0	0	6.00
7.00	Home Health Aide	0	26,439	-29,533	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 (specify)	0	-1,440	1,609	0	0	19.00
20.00	Total (sum of lines 1-19)		795,754		0	1,594	20.00
21.00	Total cost to be allocated		93,119		0	14,989	21.00
22.00	Unit cost multiplier		0.117020		0.000000	9.403388	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet H-2 Part II
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	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	7.00	7.01	8.00	9.00	10.00	
1.00 Administrative and General	0	0	0	1,594	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 (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	1,594	0	20.00
21.00 Total cost to be allocated	0	0	0	11,206	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	7.030113	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141313 HHA CCN: 147202	Period: From 10/01/2010 To 09/30/2011	Worksheet H-2 Part II Date/Time Prepared: 4/17/2012 9:54 am PPS
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	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	0	0	1,532,331	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 (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	1,532,331	20.00
21.00 Total cost to be allocated	0	0	0	0	17,898	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.011680	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141313	Period: From 10/01/2010	Worksheet H-2
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		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
1.00	Administrative and General	0	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
20.00	Total (sum of lines 1-19)	0	20.00
21.00	Total cost to be allocated	0	21.00
22.00	Unit cost multiplier	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 141313 HHA CCN: 147202		Period: From 10/01/2010 To 09/30/2011		Worksheet H-3 Parts I-II Date/Time Prepared: 4/17/2012 9:54 am	
		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	898,538		898,538	10,247	1.00
2.00	Physical Therapy	3.00	0	315,188	315,188	3,135	2.00
3.00	Occupational Therapy	4.00	0	0	0	1,989	3.00
4.00	Speech Pathology	5.00	0	0	0	62	4.00
5.00	Medical Social Services	6.00	745		745	20	5.00
6.00	Home Health Aide	7.00	35,624		35,624	1,352	6.00
7.00	Total (sum of lines 1-6)		934,907	315,188	1,250,095	16,805	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	1,727	2,043		8.00
9.00	Physical Therapy		99914	574	345		9.00
10.00	Occupational Therapy		99914	370	271		10.00
11.00	Speech Pathology		99914	15	7		11.00
12.00	Medical Social Services		99914	4	0		12.00
13.00	Home Health Aide		99914	142	306		13.00
14.00	Total (sum of lines 8-13)			2,832	2,972		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	7,500	15.00
16.00	Cost of Drugs	9.00	0	0	0	593	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	0.653572	482,255	315,188	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies		71.00	0.584040	0	0	4.00
5.00	Cost of Drugs		73.00	0.782832	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141313

Period: From 10/01/2010

Worksheet H-3

HHA CCN: 147202

To 09/30/2011

Parts I-III
Date/Time Prepared:
4/17/2012 9:54 am

Title XVIII

Home Health Agency I

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Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Part B			
			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	87.69	1,727	2,043		1.00
2.00	Physical Therapy	100.54	574	345		2.00
3.00	Occupational Therapy	0.00	370	271		3.00
4.00	Speech Pathology	0.00	15	7		4.00
5.00	Medical Social Services	37.25	4	0		5.00
6.00	Home Health Aide	26.35	142	306		6.00
7.00	Total (sum of lines 1-6)		2,832	2,972		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
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
Program Covered Charges						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000	2,399	4,349	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					2.00
3.00	Speech Pathology					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: 141313	Period: From 10/01/2010	Worksheet H-3 Parts I-III Date/Time Prepared: 4/17/2012 9:54 am
	HHA CCN: 147202	To 09/30/2011	
	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	151,441	179,151	330,592	1.00
2.00	Physical Therapy	57,710	34,686	92,396	2.00
3.00	Occupational Therapy	0	0	0	3.00
4.00	Speech Pathology	0	0	0	4.00
5.00	Medical Social Services	149	0	149	5.00
6.00	Home Health Aide	3,742	8,063	11,805	6.00
7.00	Total (sum of lines 1-6)	213,042	221,900	434,942	7.00
Cost Center Description					
		10.00	11.00	12.00	
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
9.00	Physical Therapy				9.00
10.00	Occupational Therapy				10.00
11.00	Speech Pathology				11.00
12.00	Medical Social Services				12.00
13.00	Home Health Aide				13.00
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: 141313 HHA CCN: 147202	Period: From 10/01/2010 To 09/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 4/17/2012 9:54 am
		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	0	0	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	3.00
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	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00
			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		340,042	359,319
12.00	Total PPS Reimbursement - Full Episodes with Outliers		6,882	3,151
13.00	Total PPS Reimbursement - LUPA Episodes		5,498	6,217
14.00	Total PPS Reimbursement - PEP Episodes		0	1,029
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		1,518	568
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)		353,940	370,284
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		353,940	370,284
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		353,940	370,284
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)		353,940	370,284
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		353,940	370,284
32.00	Interim payments (see instructions)		353,940	370,284
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: 141313

Period: From 10/01/2010

Worksheet H-5

HHA CCN: 147202

To 09/30/2011

Date/Time Prepared: 4/17/2012 9:54 am

Home Health Agency I

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		353,940		370,284	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)		353,940		370,284	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)		353,940		370,284	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 141313

Period: From 10/01/2010

Worksheet M-1

Component CCN: 143457

To 09/30/2011

Date/Time Prepared: 4/17/2012 9:54 am

		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	1,378,462	0	1,378,462	-88,305	1,290,157	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	238,807	0	238,807	0	238,807	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	543,047	0	543,047	0	543,047	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	2,160,316	0	2,160,316	-88,305	2,072,011	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	20,344	20,344	0	20,344	13.00
14.00	Subtotal (sum of lines 11-13)	0	20,344	20,344	0	20,344	14.00
15.00	Medical Supplies	0	33,580	33,580	0	33,580	15.00
16.00	Transportation (Health Care Staff)	0	2,195	2,195	0	2,195	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	77,722	77,722	0	77,722	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	113,497	113,497	0	113,497	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,160,316	133,841	2,294,157	-88,305	2,205,852	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	652	652	0	652	29.00
30.00	Administrative Costs	191,245	322,787	514,032	0	514,032	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	191,245	323,439	514,684	0	514,684	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,351,561	457,280	2,808,841	-88,305	2,720,536	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2010 To 09/30/2011	Worksheet M-1 Date/Time Prepared: 4/17/2012 9:54 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,290,157
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	238,807
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	543,047
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	0
10.00	Subtotal (sum of lines 1-9)	0	2,072,011
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	20,344
14.00	Subtotal (sum of lines 11-13)	0	20,344
15.00	Medical Supplies	0	33,580
16.00	Transportation (Health Care Staff)	0	2,195
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	77,722
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	113,497
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,205,852
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	652
30.00	Administrative Costs	-347	513,685
31.00	Total Facility Overhead (sum of lines 29 and 30)	-347	514,337
32.00	Total facility costs (sum of lines 22, 28 and 31)	-347	2,720,189

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2010 To 09/30/2011	Worksheet M-1 Date/Time Prepared: 4/17/2012 9:54 am
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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	56,445	0	56,445	0	56,445	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	41,780	0	41,780	0	41,780	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	52,690	0	52,690	0	52,690	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	150,915	0	150,915	0	150,915	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	5,315	5,315	0	5,315	13.00
14.00	Subtotal (sum of lines 11-13)	0	5,315	5,315	0	5,315	14.00
15.00	Medical Supplies	0	874	874	0	874	15.00
16.00	Transportation (Health Care Staff)	0	7,282	7,282	0	7,282	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	8,156	8,156	0	8,156	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	150,915	13,471	164,386	0	164,386	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	14,058	14,058	0	14,058	29.00
30.00	Administrative Costs	33,780	32,565	66,345	0	66,345	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	33,780	46,623	80,403	0	80,403	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	184,695	60,094	244,789	0	244,789	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2010 To 09/30/2011	Worksheet M-1 Date/Time Prepared: 4/17/2012 9:54 am
	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	56,445
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	41,780
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	52,690
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	0
10.00	Subtotal (sum of lines 1-9)	0	150,915
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	5,315
14.00	Subtotal (sum of lines 11-13)	0	5,315
15.00	Medical Supplies	0	874
16.00	Transportation (Health Care Staff)	0	7,282
17.00	Depreciation-Medical Equipment	0	0
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	8,156
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	164,386
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	14,058
30.00	Administrative Costs	-595	65,750
31.00	Total Facility Overhead (sum of lines 29 and 30)	-595	79,808
32.00	Total facility costs (sum of lines 22, 28 and 31)	-595	244,194

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet M-2		
		Component CCN: 143457		Date/Time Prepared: 4/17/2012 9:54 am		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	4.35	10,744	4,200	18,270	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.55	5,108	2,100	5,355	3.00
4.00	Subtotal (sum of lines 1-3)	6.90	15,852		23,625	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)	6.90	15,852		23,625	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)				2,205,852	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)				2,205,852	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)				514,337	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,203,239	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,717,576	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				1,717,576	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				1,717,576	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				3,923,428	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet M-2		
		Component CCN: 143462		Date/Time Prepared: 4/17/2012 9:54 am		
		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	0.40	847	4,200	1,680	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.45	707	2,100	945	3.00
4.00	Subtotal (sum of lines 1-3)	0.85	1,554		2,625	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)	0.85	1,554		2,625	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)				164,386	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)				164,386	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)				79,808	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				66,071	15.00
16.00	Total overhead (sum of lines 14 and 15)				145,879	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				145,879	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				145,879	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				310,265	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet M-3
		Component CCN: 143457		Date/Time Prepared: 4/17/2012 9:54 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		3,923,428	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,923,428	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		23,625	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)		23,625	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		166.07	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)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	166.07	166.07	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,321	3,964	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	219,378	658,301	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) *	219,378	658,301	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		459,062	16.04
16.05	Total program cost (see instructions)	175,502	459,062	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		84,474	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		634,564	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		634,564	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)		634,564	26.00
27.00	Interim payments		667,857	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)		-33,293	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141313	Period: From 10/01/2010 To 09/30/2011	Worksheet M-3
		Component CCN: 143462		Date/Time Prepared: 4/17/2012 9:54 am
		Title XVIIII	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)		310,265	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		310,265	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,625	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)		2,625	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		118.20	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)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	118.20	118.20	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	82	245	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	9,692	28,959	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) *	9,692	28,959	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		18,962	16.04
16.05	Total program cost (see instructions)	7,754	18,962	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,257	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		26,716	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		26,716	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)		26,716	26.00
27.00	Interim payments		22,433	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)		4,283	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2010 To 09/30/2011	Worksheet M-5 Date/Time Prepared: 4/17/2012 9:54 am
	Title VIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		667,857	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)		667,857	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		33,293	6.02
7.00	Total Medicare program liability (see instructions)		634,564	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: 141313 Component CCN: 143462	Period: From 10/01/2010 To 09/30/2011	Worksheet M-5 Date/Time Prepared: 4/17/2012 9:54 am
	Title VIII	Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		22,433	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)		22,433	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		4,283	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		26,716	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00