

Kewanee Hospital

Medicare Cost Report

Year Ended September 30, 2011

Provider No. 14-1325

Prepared By:

Wipfli LLP

469 Security Boulevard

P.O. Box 12237

Green Bay, WI 54307-2237

920.662.0016

fax 920.662.0024

COST REPORT PROCESSING SHEET

Client : Kewanee Hospital
 Biller Name: Steve Thompson
 Preparer Name: Andrew LaLuzerne

Client No. 101319

Due Date: 3/27/2012
 Firm Flexible

Job No. 264148

Delivery: Ground Delivering
 Overnight

Service Code 3041

Cost Report Type (check all that apply):

Medicare Medicaid (N/C)

	<u>HFS</u>		<u>HFS</u>
	<u>Charge</u>		<u>Charge</u>
<input type="checkbox"/> CSDRB	N/C	<input type="checkbox"/> Nursing Home	\$65
<input type="checkbox"/> Home Hlth	\$60	<input type="checkbox"/> ESRD	\$250
<input type="checkbox"/> Hospice	\$125	<input type="checkbox"/> Rural Health Clinic	\$75
<input checked="" type="checkbox"/> Hospital	\$150	<input type="checkbox"/> Home Office	\$275

PREPARATION

	<u>Initial/Date</u>	<u>Initial/Date</u>
	<u>Rework</u>	<u>Rework</u>
Prepared	ASL <u>3/27/12</u>	
Reviewed		
Release to processing		<u>ASL 3/27/12</u>
Release to client		

PROCESSING

	<u>Initial/Date</u>	<u>Initial/Date</u>
	<u>Rework</u>	<u>Rework</u>
Assembled	<u>CP 3/27/12</u>	

SPECIAL INSTRUCTIONS:

Include copy of audited financial statements
 Other:

March 27, 2012

Mr. Preston Becker, CFO
Kewanee Hospital
1051 West South Street
P.O. Box 747
Kewanee, IL 51443

Re: Medicare Cost Report

Dear Preston:

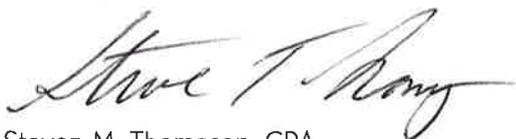
Enclosed please find the following documents accumulated in this order:

- Three copies of the Medicare cost report, a disk containing the electronic cost report, and a disk containing support for the year ended September 30, 2011. Two copies are to be signed, in blue ink, where indicated and sent to National Government Services using certified mail, in the enclosed envelope on or before April 2, 2012. The copies stamped "Your Copy" are for your files.

As indicated on Worksheet S, the Hospital will receive from the Program \$1,235,385 for services rendered during the year ended September 30, 2011.

Please call me at (920) 662-2820 if you have any questions.

Sincerely,



Steven M. Thompson, CPA
Partner

Kewanee Hospital
Medicare Cost Report Analysis

	Year Ended 9/30/2010	Year Ended 9/30/2011
Total Days		
Adults	3,239	1,983
ICU	183	164
Nursery	243	-
Swing-bed SNF	273	329
Swing-bed NF	-	55
Total Days	<u>3,938</u>	<u>2,531</u>
 Inpatient Routine Service Cost Per Diem (D-1)	 1,238.26	 1,522.18
 Medicare Days		
Adults	2,318	1,470
ICU	148	122
Swing-bed SNF	243	329
Total Medicare Days	<u>2,709</u>	<u>1,921</u>

Medicare I/P (D-1)		
Routine Service Cost	2,870,287	2,237,605
ICU	531,816	498,819
Ancillary Service Cost	<u>1,862,529</u>	<u>1,475,020</u>
Total Reimbursable Cost	5,264,632	4,211,444
Total Medicare days	<u>2,466</u>	<u>1,592</u>
Average Per Diem	<u>2,134.89</u>	<u>2,645.38</u>
Primary payer payments	0	0
101% of cost	5,317,278	4,253,558
Payments Part A (includes deductible and coinsurance)	465,937	384,462
Interim payments	4,623,857	3,126,326
Medicare Bad Debts	<u>117,942</u>	<u>104,532</u>
Amount Due From/(To) Medicare	<u>345,426</u>	<u>847,302</u>

Medicare O/P (D Part V & VI)		
Total Charges	14,777,767	13,996,781
Total Cost	<u>5,251,865</u>	<u>5,279,154</u>
Medicare O/P Cost to Charge Ratio	<u>35.54%</u>	<u>37.72%</u>
 Actual reimbursement percent based on final reimbursement	 <u>35.89%</u>	 <u>38.09%</u>
 101% of cost	 5,304,384	 5,331,946
Payments Part B (includes deductible and coinsurance)	2,256,636	2,183,498
Plus Bad Debts	547,183	550,151
Interim payments	<u>3,601,613</u>	<u>3,441,887</u>
Amount Due From/(To) Medicare	<u>(6,682)</u>	<u>256,712</u>

Medicare Swing-bed (E-2)		
Routine Service Costs	303,906	505,805
Ancillary Service Costs	<u>156,489</u>	<u>192,141</u>
Total Reimbursable costs	460,395	697,946
Total Medicare days	<u>243</u>	<u>329</u>
Average per diem	<u>1,894.63</u>	<u>2,121.42</u>
 Payments Swing Bed (includes deductible and coinsurance)	 588	 2,264
Plus Bad Debts	-	-
Interim payments	<u>397,897</u>	<u>578,099</u>
Amount Due From/(To) Medicare	<u>61,910</u>	<u>117,583</u>

Kewanee Hospital
 Medicare Cost Report Analysis

	Year Ended 9/30/2010	Year Ended 9/30/2011
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RHC (M-3)

Cost per visit	216.12	225.25
Medicare visits	872	920
Total Reimbursable visit costs	188,457	207,230
Deductible	13,353	11,872
Net Cost	175,104	195,358
	0.80	0.80
Reimbursable costs at 80%	140,083	156,286
Program costs of vaccines	-	
Total reimbursable costs	140,083	156,286
Reimbursable bad debt	-	
Total reimbursable cost with bad debts	140,083	156,286
Payments RHC (does not include deductible/coinsurance)	92,671	142,498
Amount Due From/(To) Medicare	47,412	13,788

Total Amount Due From/(To) Medicare	400,654	1,221,597
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Kewanee Hospital
 Medicare Cost Report Analysis

	Year Ended 9/30/2010	Year Ended 9/30/2011
Total Cost per Worksheet A	28,812,318	25,848,007
Medicare % of Total Cost	38%	39%
<u>Cost to Charge Ratio</u>		
Surgery	0.393659	0.394843
Delivery Room	0.946273	-
Anesthesia	0.114157	0.132702
Radiology-Diagnostic	0.763437	0.765296
Radioisotope	0.370031	0.315941
CAT Scan	0.096071	0.117228
Ultrasound	0.119062	0.155262
MRI	0.253761	0.263568
Laboratory	0.237948	0.249539
Whole Blood & Packed Red	1.117392	0.894519
Respiratory Therapy	0.188950	0.201450
Physical Therapy	0.904672	0.885841
Occupational Therapy	1.110756	1.109939
Speech Therapy	1.820412	1.992925
Cardio-Pulmonary	0.277983	0.282327
Vascular Lab	0.460207	0.277130
Imp. Dev Charged to Patients	-	0.870987
Drugs Charged to Patients	0.485707	0.521606
Emergency	0.612598	0.623620
Observation Beds	0.896035	1.464865
Durable Medical Equipment	0.920614	-
Medicare inpatient ancillary charges	1,862,529	1,475,020
Medicare days	2,466	1,592
Medicare ancillary charges per day	<u>755.28</u>	<u>926.52</u>

March 27, 2012

National Government Services, Inc.
Medicare Audit and Reimbursement
6775 West Washington Street
Milwaukee, WI 53214

Re: Kewanee Hospital
Provider No. 14-1325
Year Ended September 30, 2011

Enclosed please find the following for Kewanee Hospital provider number 14-1325, for the year ended September 30, 2011:

- Two copies of the Medicare cost report
- One copy of the CMS-339 Exhibit 1
- One CD containing:
 - The electronic submission of the Medicare cost report
 - Supporting workpapers

If you have any questions, please call me at (920) 662-2820.

Sincerely,



Steven M. Thompson, CPA
Partner

Enc.

cc: Mr. Preston Becker, Kewanee Hospital



Accountant's Compilation Report

Board of Trustees
Kewanee Hospital
Kewanee, Illinois

We have compiled the Medicare Cost Report ("cost report") for Kewanee Hospital (provider 14-1325) for the year ended September 30, 2011, included in the accompanying prescribed form (Form CMS 2552-10). We have not audited or reviewed the accompanying cost report and, accordingly, do not express an opinion or provide any assurance about whether the cost report is in accordance with the form prescribed by the Centers for Medicare and Medicaid Services.

Management is responsible for the preparation and fair presentation of the cost report in accordance with the form prescribed by the Centers for Medicare and Medicaid Services and for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the cost report.

Our responsibility is to conduct the compilation in accordance with *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants. The objective of a compilation is to assist management in presenting financial information in the form prescribed by the Centers for Medicare and Medicaid Services without undertaking to obtain or provide any assurance that there are no material modifications that should be made to the financial information.

The financial information included in the accompanying cost report is presented in accordance with the requirements of the Centers for Medicare and Medicaid Services, which differs from accounting principles generally accepted in the United States. This report is intended solely for the information and use of the Centers for Medicare and Medicaid Services and is not intended to be and should not be used by anyone other than this specified party.

A handwritten signature in cursive script that reads "Wipfli LLP".

Wipfli LLP

March 27, 2012
Green Bay, Wisconsin

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: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/27/2012 10:32 am
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report	Date: 3/27/2012	Time: 10:32 am
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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 KEWANEE 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.

Encryption Information

ECR: Date: 3/27/2012 Time: 10:32 am
dfmP06ADV0UqCoalSpYG4tkMu53tQ0
MGtey00YFqrHGwp7P9YvI.UWXHDRYG
PMOz0NjvY70tkv3l
PI: Date: 3/27/2012 Time: 10:32 am
ehIq:b8JYDcZ7jXzUE1:7kRFcmrYi0
dJEo90ETBuEYoj7tQgYDEIfYm2XG9
TIRZKH214Z0H9QSh

(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	847,302	256,712	1,220,283	2,728,719	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	117,583	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		13,788		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	964,885	270,500	1,220,283	2,728,719	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.

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: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/27/2012 10:30 am
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report	Date:	Time:
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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 KEWANEE 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 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	847,302	256,712	1,220,283	2,728,719	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	117,583	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		13,788		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	964,885	270,500	1,220,283	2,728,719	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 141325		Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 3/27/2012 10:30 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1051 WEST SOUTH STREET			PO Box: 747				1.00			
2.00	City: KEWANEE			State: IL		Zip Code: 61443-		County: HENRY			
				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	V	XVIII	XIX
								6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			KEWANEE HOSPITAL	141325	99914	1	07/01/1966	N	O	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF			KEWANEE SWING BED	142325	99914		03/19/2003	N	O	N
8.00	Swing Beds - NF			KEWANEE SWING BED	142325	99914		03/19/2003	N		N
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA								N	N	N
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC			FAMILY HEALTH CLINIC	143445	99914		10/01/1998	N	O	N
16.00	Hospital-Based Health Clinic - FQHC								N	N	N
17.00	Hospital-Based (CMHC) 1										
17.10	Hospital-Based (CORF) 1								N	N	N
18.00	Renal Dialysis										
19.00	Other										
								From:	To:		
								1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)							10/01/2010	09/30/2011		20.00
21.00	Type of Control (see instructions)							2		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		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.							0 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		
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.			0	0	0	0	0	0		
								1.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.									2	
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	
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	
								Beginning:	Ending:		
								1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.										
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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/27/2012 10:30 am		
		Beginning: 1.00		Ending: 2.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00			62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/27/2012 10:30 am		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0.00	0.00	0.000000		67.00
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N				80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N				85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N				86.00
		V		XIX		
		1.00		2.00		
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/27/2012 10:30 am	
		V 1.00	XIX 2.00		
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.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	6,000,000		6,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:		Zip Code:	143.00
				1.00	
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/27/2012 10:30 am
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		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
161.10	CORF		N	161.10

		1.00		
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Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00		
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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.				Y	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)				1,220,283	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 3/27/2012 10:30 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	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 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.		Y	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
		Description 0	Part A Y/N 1.00	Date 2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/02/2012	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	
0		1.00	2.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	were assets subject to sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	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.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/02/2012	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: 141325

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

Worksheet S-3
Part I
Date/Time Prepared:
3/27/2012 10:30 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	22	8,030	47,592.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	47,592.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,095	3,936.00		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	43.00					13.00
14.00 Total (see instructions)		25	9,125	51,528.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,470	193	1,983		1.00
2.00 HMO		20	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	329	0	329		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	55		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,799	193	2,367		7.00
8.00 INTENSIVE CARE UNIT	0	122	2	164		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	0		0	0		13.00
14.00 Total (see instructions)	0	1,921	195	2,531		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	925	4,240	10,310		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	149		28.00
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				12		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: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet S-3 Part I Date/Time Prepared: 3/27/2012 10:30 am
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Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	492	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	183.61	0.00	0	492	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	15.45	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	199.06	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	73	710		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)	73	710		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN:143445	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/27/2012 10:30 am
			Rural Health Clinic (RHC) I	Cost
			1.00	
1.00	Clinic Address and Identification			
	Street		1051 WEST SOUTH STREET	1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County		IL 61443	2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)		0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00
7.00	Appalachian Regional Commission		0	7.00
8.00	Look-Alikes		0	8.00
9.00	OTHER (SPECIFY)		0	9.00
			1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0 10.00
		Sunday	Monday	
		from	to	from
		1.00	2.00	3.00
		to	from	to
		2.00	3.00	4.00
	Facility hours of operations (1)			
11.00	Clinic		09:00	19:00
			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
		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 15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/27/2012 10:30 am	
			Rural Health Clinic (RHC) I	Cost	
		County			
		4.00			
2.00	City, State, Zip Code, County	HENRY			2.00
		Tuesday		Wednesday	
		from	to	from	to
		5.00	6.00	7.00	8.00
11.00	Facility hours of operations (1) Clinic	09:00	17:00	09:00	17:00
					11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN:143445	Period: From 10/01/2010 To 09/30/2011	Worksheet S-8 Date/Time Prepared: 3/27/2012 10:30 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	09:00	19:00	09:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN:143445	Period: From 10/01/2010 To 09/30/2011	worksheet S-8 Date/Time Prepared: 3/27/2012 10:30 am
			Rural Health Clinic (RHC) I	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	worksheet S-10 Date/Time Prepared: 3/27/2012 10:30 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)		0.484394	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,981,483	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		10,375,469	6.00
7.00	Medicaid cost (line 1 times line 6)		5,025,815	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)		3,044,332	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		3,044,332	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,463,817	703,817	4,167,634
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,677,852	340,925	2,018,777
22.00	Partial payment by patients approved for charity care	66,321	43,401	109,722
23.00	Cost of charity care (line 21 minus line 22)	1,611,531	297,524	1,909,055
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,211,834	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		654,683	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,557,151	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		754,275	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,663,330	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,707,662	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet A	Date/Time Prepared: 3/27/2012 10:30 am
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT		3,084,206		429,154	3,513,360
2.00	NEW CAP REL COSTS-MVBLE EQUIP		1,261,005		0	1,261,005
4.00	EMPLOYEE BENEFITS	164,934	1,858,804		0	2,023,738
5.00	ADMINISTRATIVE & GENERAL	1,792,275	3,115,371		-428,079	4,479,567
7.00	OPERATION OF PLANT	270,572	744,833		0	1,015,405
8.00	LAUNDRY & LINEN SERVICE	0	117,961		0	117,961
9.00	HOUSEKEEPING	223,644	50,119		0	273,763
10.00	DIETARY	234,225	131,443		-234,916	130,752
11.00	CAFETERIA	0	0		234,916	234,916
13.00	NURSING ADMINISTRATION	0	1,613		0	1,613
14.00	CENTRAL SERVICES & SUPPLY	24,630	23,381		0	48,011
15.00	PHARMACY	78,684	735,805		0	814,489
16.00	MEDICAL RECORDS & LIBRARY	283,785	73,939		0	357,724
17.00	SOCIAL SERVICE	0	0		0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	923,210	771,463	1,694,673	30,560	1,725,233
31.00	INTENSIVE CARE UNIT	222,870	31,791	254,661	1,596	256,257
41.00	SUBPROVIDER - IRF	0	0	0	0	0
42.00	SUBPROVIDER	0	0	0	0	0
43.00	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	498,112	694,038	1,192,150	97,003	1,289,153
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	ANESTHESIOLOGY	383,409	75,974	459,383	0	459,383
54.00	RADIOLOGY-DIAGNOSTIC	714,628	871,645	1,586,273	-712,534	873,739
56.00	RADIOISOTOPE	0	0	0	172,439	172,439
56.01	ULTRASOUND	0	0	0	64,927	64,927
57.00	CT SCAN	0	0	0	212,848	212,848
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	217,414	217,414
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	502,781	783,873	1,286,654	-58,163	1,228,491
60.01	BLOOD LABORATORY	0	0	0	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	78,527	78,527
65.00	RESPIRATORY THERAPY	0	0	0	209,097	209,097
66.00	PHYSICAL THERAPY	461,899	39,998	501,897	0	501,897
67.00	OCCUPATIONAL THERAPY	218,564	5,402	223,966	0	223,966
68.00	SPEECH PATHOLOGY	141,010	6,612	147,622	0	147,622
69.01	CARDIO-PULMONARY	259,252	42,528	301,780	-209,097	92,683
69.02	VASCULAR LAB	0	0	0	44,906	44,906
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,761	46,761
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	ONCOLOGY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	1,070,131	89,318	1,159,449	-197,587	961,862
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	EMERGENCY	759,375	1,830,613	2,589,988	228	2,590,216
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10	CORF	0	0	0	0	0
101.00	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0
110.00	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	ISLET ACQUISITION	0	0	0	0	0
116.00	HOSPICE	353	10,365	10,718	0	10,718
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,228,343	16,452,100	25,680,443	0	25,680,443
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,407	32,713	38,120	0	38,120
190.01	FOUNDATION	32,382	36,807	69,189	0	69,189
190.02	DURABLE MEDICAL EQUIP-RENTED	353	42,848	43,201	0	43,201
192.00	PHYSICIANS' PRIVATE OFFICES	0	17,054	17,054	0	17,054
200.00	TOTAL (SUM OF LINES 118-199)	9,266,485	16,581,522	25,848,007	0	25,848,007

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141325

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

Worksheet A
Date/Time Prepared:
3/27/2012 10:30 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	-277,694	3,235,666	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-290,247	970,758	2.00
4.00	EMPLOYEE BENEFITS	-750	2,022,988	4.00
5.00	ADMINISTRATIVE & GENERAL	-45,001	4,434,566	5.00
7.00	OPERATION OF PLANT	0	1,015,405	7.00
8.00	LAUNDRY & LINEN SERVICE	0	117,961	8.00
9.00	HOUSEKEEPING	0	273,763	9.00
10.00	DIETARY	0	130,752	10.00
11.00	CAFETERIA	-85,558	149,358	11.00
13.00	NURSING ADMINISTRATION	0	1,613	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	48,011	14.00
15.00	PHARMACY	0	814,489	15.00
16.00	MEDICAL RECORDS & LIBRARY	-654	357,070	16.00
17.00	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-630,924	1,094,309	30.00
31.00	INTENSIVE CARE UNIT	0	256,257	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-175,224	1,113,929	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	-424,503	34,880	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	873,739	54.00
56.00	RADIOISOTOPE	0	172,439	56.00
56.01	ULTRASOUND	0	64,927	56.01
57.00	CT SCAN	0	212,848	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	217,414	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	-24,360	1,204,131	60.00
60.01	BLOOD LABORATORY	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	78,527	62.00
65.00	RESPIRATORY THERAPY	0	209,097	65.00
66.00	PHYSICAL THERAPY	-18,740	483,157	66.00
67.00	OCCUPATIONAL THERAPY	0	223,966	67.00
68.00	SPEECH PATHOLOGY	0	147,622	68.00
69.01	CARDIO-PULMONARY	0	92,683	69.01
69.02	VASCULAR LAB	0	44,906	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	46,761	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	ONCOLOGY	0	0	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	961,862	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	-1,228,776	1,361,440	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
116.00	HOSPICE	0	10,718	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-3,202,431	22,478,012	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,120	190.00
190.01	FOUNDATION	0	69,189	190.01
190.02	DURABLE MEDICAL EQUIP-RENTED	0	43,201	190.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	17,054	192.00
200.00	TOTAL (SUM OF LINES 118-199)	-3,202,431	22,645,576	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - PROPERTY TAX EXP					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	429,154	1.00
	TOTALS		0	429,154	
C - CAFETERIA					
1.00	CAFETERIA	11.00	150,473	84,443	1.00
	TOTALS		150,473	84,443	
D - BLOOD COSTS					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	7,884	70,643	1.00
	TOTALS		7,884	70,643	
E - RESPIRATORY THERAPY					
1.00	RESPIRATORY THERAPY	65.00	160,840	48,257	1.00
	TOTALS		160,840	48,257	
G - RADIOLOGY SERVICES					
1.00	RADIOISOTOPE	56.00	0	172,439	1.00
2.00	CT SCAN	57.00	86,570	126,278	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	217,414	3.00
4.00	VASCULAR LAB	69.02	0	44,906	4.00
5.00	ULTRASOUND	56.01	64,927	0	5.00
	TOTALS		151,497	561,037	
H - HOSPITAL COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,556	1.00
2.00	LABORATORY	60.00	0	20,364	2.00
3.00	RURAL HEALTH CLINIC	88.00	481	0	3.00
	TOTALS		481	21,920	
I - CASE MANAGERS/DIR NSG					
1.00	ADULTS & PEDIATRICS	30.00	50,311	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	1,596	0	2.00
3.00	EMERGENCY	91.00	228	0	3.00
	TOTALS		52,135	0	
J - PROFESSIONAL SALARIES IN RHC					
1.00	OPERATING ROOM	50.00	175,224	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	924	0	2.00
	TOTALS		176,148	0	
K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	46,761	1.00
	TOTALS		0	46,761	
500.00	Grand Total: Increases		699,458	1,262,215	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - PROPERTY TAX EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	429,154	12		1.00
	TOTALS		0	429,154			
C - CAFETERIA							
1.00	DIETARY	10.00	150,473	84,443	0		1.00
	TOTALS		150,473	84,443			
D - BLOOD COSTS							
1.00	LABORATORY	60.00	7,884	70,643	0		1.00
	TOTALS		7,884	70,643			
E - RESPIRATORY THERAPY							
1.00	CARDIO-PULMONARY	69.01	160,840	48,257	0		1.00
	TOTALS		160,840	48,257			
G - RADIOLOGY SERVICES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	151,497	561,037	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		151,497	561,037			
H - HOSPITAL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	481	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	21,920	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		481	21,920			
I - CASE MANAGERS/DIR NSG							
1.00	ADULTS & PEDIATRICS	30.00	20,675	0	0		1.00
2.00	OPERATING ROOM	50.00	31,460	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		52,135	0			
J - PROFESSIONAL SALARIES IN RHC							
1.00	RURAL HEALTH CLINIC	88.00	176,148	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		176,148	0			
K - IMPLANTABLE DEVICES							
1.00	OPERATING ROOM	50.00	0	46,761	0		1.00
	TOTALS		0	46,761			
500.00	Grand Total: Decreases		699,458	1,262,215			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141325

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
3/27/2012 10:30 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	2,103,329	0	0	0	2.00
3.00	Buildings and Fixtures	19,659,425	5,850	0	5,850	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	20,480,407	257,142	0	257,142	6.00
7.00	HIT designated Assets	1,364,884	413,154	0	413,154	7.00
8.00	Subtotal (sum of lines 1-7)	43,608,045	676,146	0	676,146	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	43,608,045	676,146	0	676,146	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	3,084,206	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,261,005	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,345,211	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance
		1.00	2.00	3.00	4.00	5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	21,560,262	0	21,560,262	0.490471	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	22,397,993	0	22,397,993	0.509529	2.00
3.00	Total (sum of lines 1-2)	43,958,255	0	43,958,255	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141325

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

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	0	0		1.00		
2.00	Land Improvements	1,894,987	0		2.00		
3.00	Buildings and Fixtures	19,665,275	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	20,619,955	0		6.00		
7.00	HIT designated Assets	1,778,038	0		7.00		
8.00	Subtotal (sum of lines 1-7)	43,958,255	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	43,958,255	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	3,084,206		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,261,005		2.00		
3.00	Total (sum of lines 1-2)	0	4,345,211		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	3,083,879	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	970,758	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,054,637	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141325

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-277,367	429,154	0	0	3,235,666	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	970,758	2.00
3.00	Total (sum of lines 1-2)	-277,367	429,154	0	0	4,206,424	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141325

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

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	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)		0			0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		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	-2,059,284				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	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist		0		*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0			0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00
33.00 PROVIDER TAX	A	-429,552		ADMINISTRATIVE & GENERAL	5.00	33.00
33.01 CAFETERIA--EMPLOYEES AND GUESTS	B	-85,558		CAFETERIA	11.00	33.01
33.08 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-654		MEDICAL RECORDS & LIBRARY	16.00	33.08
33.14 MISC PT SALES	B	-18,740		PHYSICAL THERAPY	66.00	33.14
33.20 FITNESS FEES	B	-275		EMPLOYEE BENEFITS	4.00	33.20
33.23 MEDICAL STAFF FEES	B	-4,300		ADMINISTRATIVE & GENERAL	5.00	33.23
33.26 OTHER MISC INCOME	B	-837		ADMINISTRATIVE & GENERAL	5.00	33.26
34.00 MEDICAL STAFF DUES TRAVELING DR'S	B	-11,400		ADMINISTRATIVE & GENERAL	5.00	34.00
35.00 INVST INCOME-NEW BLDGS AND FIXTURES	B	-277,367		NEW CAP REL COSTS-BLDG & FIXT	1.00	35.00
37.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	37.00
38.00 PATIENT TELEPHONE COSTS - SALARIES	A	-2,169		ADMINISTRATIVE & GENERAL	5.00	38.00
39.00 PATIENT TELEPHONE COSTS - BENE	A	-475		EMPLOYEE BENEFITS	4.00	39.00
40.00 PATIENT TELEPHONE COSTS - OTHER	A	-1,005		ADMINISTRATIVE & GENERAL	5.00	40.00
41.00 PATIENT TELEPHONE COSTS - DEPRE	A	-327		NEW CAP REL COSTS-BLDG & FIXT	1.00	41.00
42.00 CRNA	A	-424,503		ANESTHESIOLOGY	53.00	42.00
43.00 LOBBYING PORTION OF DUES	A	-18,042		ADMINISTRATIVE & GENERAL	5.00	43.00
43.02 NON-REIMB EXP- ADMIN	A	-208		ADMINISTRATIVE & GENERAL	5.00	43.02
43.04 CPR REVENUE	B	-955		ADMINISTRATIVE & GENERAL	5.00	43.04

Provider CCN: 141325 Period: From 10/01/2010 To 09/30/2011 Worksheet A-8
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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		Line #	
			Cost Center	Line #		
			1.00	2.00		
44.00 NON-ALLOWABLE ADVERTISING	A	-6,085	ADMINISTRATIVE & GENERAL	5.00	44.00	
44.01 EMR EQUIPMENT DEPRECIATION EXPENSE	A	-290,247	NEW CAP REL COSTS-MVBLE EQUIP	2.00	44.01	
44.02 PROVIDER TAX	A	429,552	ADMINISTRATIVE & GENERAL	5.00	44.02	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-3,202,431			50.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 141325

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

Worksheet A-8

Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
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
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	PROVIDER TAX	0	33.00
33.01	CAFETERIA--EMPLOYEES AND GUESTS	0	33.01
33.08	SALE OF MEDICAL RECORDS & ABSTRACTS	0	33.08
33.14	MISC PT SALES	0	33.14
33.20	FITNESS FEES	0	33.20
33.23	MEDICAL STAFF FEES	0	33.23
33.26	OTHER MISC INCOME	0	33.26
34.00	MEDICAL STAFF DUES TRAVELING DR'S	0	34.00
35.00	INVST INCOME-NEW BLDGS AND FIXTURES	11	35.00
37.00	OTHER ADJUSTMENTS (SPECIFY)	0	37.00
38.00	PATIENT TELEPHONE COSTS - SALARIES	0	38.00
39.00	PATIENT TELEPHONE COSTS - BENE	0	39.00
40.00	PATIENT TELEPHONE COSTS - OTHER	0	40.00
41.00	PATIENT TELEPHONE COSTS - DEPRE	9	41.00
42.00	CRNA	0	42.00
43.00	LOBBYING PORTION OF DUES	0	43.00
43.02	NON-REIMB EXP- ADMIN	0	43.02
43.04	CPR REVENUE	0	43.04
44.00	NON-ALLOWABLE ADVERTISING	0	44.00
44.01	EMR EQUIPMENT DEPRECIATION EXPENSE	9	44.01
44.02	PROVIDER TAX	0	44.02
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: 141325

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

Worksheet A-8-2

Date/Time Prepared:
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	1.00	2.00	3.00	4.00	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
1.00	30.00	MEDICAL DIRECTOR	1,800	0	1.00
2.00	60.00	LABORATORY	24,360	24,360	2.00
3.00	91.00	EMERGENCY	1,625,365	1,228,776	3.00
4.00	30.00	HOSPITALIST	630,000	630,000	4.00
5.00	30.00	FAMILY PRACTICE	924	924	5.00
6.00	50.00	SURGEON	175,224	175,224	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	2,457,673	2,059,284	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141325

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	1,800	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	396,589	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	398,389		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141325

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

Worksheet A-8-2

Date/Time Prepared:
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	Cost of Memberships & Continuing Education 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: 141325

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

Worksheet A-8-2

Date/Time Prepared:
3/27/2012 10:30 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	0	24,360	2.00
3.00	0	1,228,776	3.00
4.00	0	630,000	4.00
5.00	0	924	5.00
6.00	0	175,224	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	2,059,284	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

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

Worksheet B
Part I
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,235,666	3,235,666			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	970,758		970,758		2.00
4.00	EMPLOYEE BENEFITS	2,022,988	14,602	1,083	2,038,673	4.00
5.00	ADMINISTRATIVE & GENERAL	4,434,566	512,469	61,733	401,561	5.00
7.00	OPERATION OF PLANT	1,015,405	272,900	13,835	60,606	7.00
8.00	LAUNDRY & LINEN SERVICE	117,961	13,897	0	0	8.00
9.00	HOUSEKEEPING	273,763	26,719	1,570	50,094	9.00
10.00	DIETARY	130,752	74,385	10,745	18,760	10.00
11.00	CAFETERIA	149,358	25,377	0	33,705	11.00
13.00	NURSING ADMINISTRATION	1,613	9,667	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	48,011	0	12,196	5,517	14.00
15.00	PHARMACY	814,489	45,685	3,413	17,625	15.00
16.00	MEDICAL RECORDS & LIBRARY	357,070	63,207	2,197	63,565	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,094,309	606,052	49,978	206,629	30.00
31.00	INTENSIVE CARE UNIT	256,257	85,663	18,075	50,063	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,113,929	321,741	118,495	111,573	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	34,880	4,532	6,630	85,880	53.00
54.00	RADIOLOGY-DIAGNOSTIC	873,739	155,516	322,032	126,136	54.00
56.00	RADIOISOTOPE	172,439	9,063	0	0	56.00
56.01	ULTRASOUND	64,927	7,855	33,741	14,543	56.01
57.00	CT SCAN	212,848	12,688	160,534	19,391	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	217,414	25,981	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	1,204,131	66,329	51,263	110,852	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	78,527	6,042	0	1,766	62.00
65.00	RESPIRATORY THERAPY	209,097	18,730	0	36,027	65.00
66.00	PHYSICAL THERAPY	483,157	113,054	9,292	103,461	66.00
67.00	OCCUPATIONAL THERAPY	223,966	10,272	4,966	48,956	67.00
68.00	SPEECH PATHOLOGY	147,622	3,625	1,209	31,585	68.00
69.01	CARDIO-PULMONARY	92,683	55,856	29,157	22,043	69.01
69.02	VASCULAR LAB	44,906	3,625	0	0	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	46,761	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	961,862	314,994	8,387	239,592	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	EMERGENCY	1,361,440	237,084	45,018	170,113	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
99.10	CORF	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
116.00	HOSPICE	10,718	0	151	87	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,478,012	3,117,610	965,700	2,030,130	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,120	30,714	318	1,211	190.00
190.01	FOUNDATION	69,189	0	3,537	7,253	190.01
190.02	DURABLE MEDICAL EQUIP-RENTED	43,201	0	383	79	190.02
192.00	PHYSICIANS' PRIVATE OFFICES	17,054	87,342	820	0	192.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	22,645,576	3,235,666	970,758	2,038,673	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

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

Worksheet B
Part I
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	5,410,329					5.00
7.00 OPERATION OF PLANT	427,781	1,790,527				7.00
8.00 LAUNDRY & LINEN SERVICE	41,392	10,216	183,466			8.00
9.00 HOUSEKEEPING	110,543	19,642	1,843	484,174		9.00
10.00 DIETARY	73,657	54,682	247	18,288	381,516	10.00
11.00 CAFETERIA	65,432	18,655	0	0	0	11.00
13.00 NURSING ADMINISTRATION	3,541	7,107	0	3,962	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	20,631	0	486	5,182	0	14.00
15.00 PHARMACY	276,622	33,584	0	6,858	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	152,573	46,465	0	457	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	614,310	445,522	71,236	204,521	352,374	30.00
31.00 INTENSIVE CARE UNIT	128,722	62,973	3,055	14,021	29,142	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	522,893	236,518	19,144	49,378	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	41,412	3,331	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	463,779	114,323	9,042	38,557	0	54.00
56.00 RADIOISOTOPE	56,975	6,662	0	0	0	56.00
56.01 ULTRASOUND	38,004	5,774	0	0	0	56.01
57.00 CT SCAN	127,279	9,327	0	4,115	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	76,404	19,099	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	449,701	48,759	0	21,031	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	27,102	4,442	0	0	0	62.00
65.00 RESPIRATORY THERAPY	82,827	13,769	0	0	0	65.00
66.00 PHYSICAL THERAPY	222,552	83,108	9,478	23,774	0	66.00
67.00 OCCUPATIONAL THERAPY	90,457	7,551	0	6,401	0	67.00
68.00 SPEECH PATHOLOGY	57,772	2,665	0	5,334	0	68.00
69.01 CARDIO-PULMONARY	62,700	41,061	8,527	7,010	0	69.01
69.02 VASCULAR LAB	15,234	2,665	0	3,962	0	69.02
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	14,679	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	478,662	231,558	0	17,678	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	569,326	174,285	60,408	39,167	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 HOSPICE	3,439	0	0	762	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5,316,401	1,703,743	183,466	470,458	381,516	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,088	22,578	0	0	0	190.00
190.01 FOUNDATION	25,106	0	0	0	0	190.01
190.02 DURABLE MEDICAL EQUIP-RENTED	13,706	0	0	914	0	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	33,028	64,206	0	12,802	0	192.00
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)	5,410,329	1,790,527	183,466	484,174	381,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

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

Worksheet B
Part I
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	292,527					11.00
13.00	NURSING ADMINISTRATION	0	25,890				13.00
14.00	CENTRAL SERVICES & SUPPLY	2,095	0	94,118			14.00
15.00	PHARMACY	3,953	606	0	1,202,835		15.00
16.00	MEDICAL RECORDS & LIBRARY	19,424	0	0	0	704,958	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	48,901	7,493	4,880	0	46,609	30.00
31.00	INTENSIVE CARE UNIT	11,685	1,791	1,206	0	7,890	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	20,639	3,163	57,176	0	103,513	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	4,535	0	0	0	23,546	53.00
54.00	RADIOLOGY-DIAGNOSTIC	26,496	4,060	0	0	43,414	54.00
56.00	RADIOISOTOPE	0	0	0	0	12,442	56.00
56.01	ULTRASOUND	4,535	695	0	0	18,539	56.01
57.00	CT SCAN	3,401	521	0	0	82,332	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	20,829	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	26,495	0	0	0	128,865	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	422	0	0	0	2,053	62.00
65.00	RESPIRATORY THERAPY	8,763	1,343	0	0	30,373	65.00
66.00	PHYSICAL THERAPY	20,722	0	0	0	18,732	66.00
67.00	OCCUPATIONAL THERAPY	7,380	0	0	0	5,576	67.00
68.00	SPEECH PATHOLOGY	5,111	0	0	0	1,967	68.00
69.01	CARDIO-PULMONARY	5,358	821	0	0	18,584	69.01
69.02	VASCULAR LAB	0	0	0	0	4,102	69.02
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	1,096	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	1,202,835	36,253	73.00
73.01	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	35,037	0	5,109	0	29,406	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	1	89.00
91.00	EMERGENCY	35,223	5,397	25,747	0	68,313	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00	HOSPICE	0	0	0	0	523	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	290,175	25,890	94,118	1,202,835	704,958	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	471	0	0	0	0	190.00
190.01	FOUNDATION	1,881	0	0	0	0	190.01
190.02	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	292,527	25,890	94,118	1,202,835	704,958	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

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

Worksheet B
Part I
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	0	3,752,814	0	3,752,814	30.00
31.00 INTENSIVE CARE UNIT	0	670,543	0	670,543	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	2,678,162	0	2,678,162	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	204,746	0	204,746	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	2,177,094	0	2,177,094	54.00
56.00 RADIOISOTOPE	0	257,581	0	257,581	56.00
56.01 ULTRASOUND	0	188,613	0	188,613	56.01
57.00 CT SCAN	0	632,436	0	632,436	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	359,727	0	359,727	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	2,107,426	0	2,107,426	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	120,354	0	120,354	62.00
65.00 RESPIRATORY THERAPY	0	400,929	0	400,929	65.00
66.00 PHYSICAL THERAPY	0	1,087,330	0	1,087,330	66.00
67.00 OCCUPATIONAL THERAPY	0	405,525	0	405,525	67.00
68.00 SPEECH PATHOLOGY	0	256,890	0	256,890	68.00
69.01 CARDIO-PULMONARY	0	343,800	0	343,800	69.01
69.02 VASCULAR LAB	0	74,494	0	74,494	69.02
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	62,536	0	62,536	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,239,088	0	1,239,088	73.00
73.01 ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	2,322,285	0	2,322,285	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0	1	89.00
91.00 EMERGENCY	0	2,791,521	0	2,791,521	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS					
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
99.10 CORF	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	111.00
116.00 HOSPICE	0	15,680	0	15,680	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	22,149,575	0	22,149,575	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	115,500	0	115,500	190.00
190.01 FOUNDATION	0	106,966	0	106,966	190.01
190.02 DURABLE MEDICAL EQUIP-RENTED	0	58,283	0	58,283	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0	215,252	0	215,252	192.00
200.00 Cross Foot Adjustments	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	22,645,576	0	22,645,576	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141325

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

Worksheet B
Part II
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	14,602	1,083	15,685	15,685 4.00
5.00	ADMINISTRATIVE & GENERAL	0	512,469	61,733	574,202	3,091 5.00
7.00	OPERATION OF PLANT	0	272,900	13,835	286,735	466 7.00
8.00	LAUNDRY & LINEN SERVICE	0	13,897	0	13,897	0 8.00
9.00	HOUSEKEEPING	0	26,719	1,570	28,289	385 9.00
10.00	DIETARY	0	74,385	10,745	85,130	144 10.00
11.00	CAFETERIA	0	25,377	0	25,377	259 11.00
13.00	NURSING ADMINISTRATION	0	9,667	0	9,667	0 13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	12,196	12,196	42 14.00
15.00	PHARMACY	0	45,685	3,413	49,098	136 15.00
16.00	MEDICAL RECORDS & LIBRARY	0	63,207	2,197	65,404	489 16.00
17.00	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	606,052	49,978	656,030	1,589 30.00
31.00	INTENSIVE CARE UNIT	0	85,663	18,075	103,738	385 31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	SUBPROVIDER	0	0	0	0	0 42.00
43.00	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	321,741	118,495	440,236	858 50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	ANESTHESIOLOGY	0	4,532	6,630	11,162	661 53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	155,516	322,032	477,548	970 54.00
56.00	RADIOISOTOPE	0	9,063	0	9,063	0 56.00
56.01	ULTRASOUND	0	7,855	33,741	41,596	112 56.01
57.00	CT SCAN	0	12,688	160,534	173,222	149 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	25,981	0	25,981	0 58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	LABORATORY	0	66,329	51,263	117,592	853 60.00
60.01	BLOOD LABORATORY	0	0	0	0	0 60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6,042	0	6,042	14 62.00
65.00	RESPIRATORY THERAPY	0	18,730	0	18,730	277 65.00
66.00	PHYSICAL THERAPY	0	113,054	9,292	122,346	796 66.00
67.00	OCCUPATIONAL THERAPY	0	10,272	4,966	15,238	377 67.00
68.00	SPEECH PATHOLOGY	0	3,625	1,209	4,834	243 68.00
69.01	CARDIO-PULMONARY	0	55,856	29,157	85,013	170 69.01
69.02	VASCULAR LAB	0	3,625	0	3,625	0 69.02
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
73.01	ONCOLOGY	0	0	0	0	0 73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	314,994	8,387	323,381	1,843 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	EMERGENCY	0	237,084	45,018	282,102	1,309 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
99.10	CORF	0	0	0	0	0 99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	ISLET ACQUISITION	0	0	0	0	0 111.00
116.00	HOSPICE	0	0	151	151	1 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,117,610	965,700	4,083,310	15,619 118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,714	318	31,032	9 190.00
190.01	FOUNDATION	0	0	3,537	3,537	56 190.01
190.02	DURABLE MEDICAL EQUIP-RENTED	0	0	383	383	1 190.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	87,342	820	88,162	0 192.00
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)	0	3,235,666	970,758	4,206,424	15,685 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141325

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

Worksheet B
Part II
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00	577,293					5.00
7.00	45,645	332,846				7.00
8.00	4,417	1,899	20,213			8.00
9.00	11,795	3,651	203	44,323		9.00
10.00	7,859	10,165	27	1,674	104,999	10.00
11.00	6,982	3,468	0	0	0	11.00
13.00	378	1,321	0	363	0	13.00
14.00	2,201	0	54	474	0	14.00
15.00	29,516	6,243	0	628	0	15.00
16.00	16,280	8,637	0	42	0	16.00
17.00	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	65,548	82,820	7,849	18,722	96,979	30.00
31.00	13,735	11,706	337	1,284	8,020	31.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
43.00	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	55,794	43,967	2,109	4,520	0	50.00
52.00	0	0	0	0	0	52.00
53.00	4,419	619	0	0	0	53.00
54.00	49,486	21,252	996	3,530	0	54.00
56.00	6,079	1,239	0	0	0	56.00
56.01	4,055	1,073	0	0	0	56.01
57.00	13,581	1,734	0	377	0	57.00
58.00	8,153	3,550	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	47,984	9,064	0	1,925	0	60.00
60.01	0	0	0	0	0	60.01
62.00	2,892	826	0	0	0	62.00
65.00	8,838	2,560	0	0	0	65.00
66.00	23,747	15,449	1,044	2,176	0	66.00
67.00	9,652	1,404	0	586	0	67.00
68.00	6,164	495	0	488	0	68.00
69.01	6,690	7,633	939	642	0	69.01
69.02	1,626	495	0	363	0	69.02
71.00	0	0	0	0	0	71.00
72.00	1,566	0	0	0	0	72.00
73.00	0	0	0	0	0	73.00
73.01	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	51,074	43,045	0	1,618	0	88.00
89.00	0	0	0	0	0	89.00
91.00	60,748	32,398	6,655	3,585	0	91.00
92.00						92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	0	0	0	0	0	96.00
99.10	0	0	0	0	0	99.10
101.00	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	0	0	0	0	0	109.00
110.00	0	0	0	0	0	110.00
111.00	0	0	0	0	0	111.00
116.00	367	0	0	70	0	116.00
118.00	567,271	316,713	20,213	43,067	104,999	118.00
NONREIMBURSABLE COST CENTERS						
190.00	2,357	4,197	0	0	0	190.00
190.01	2,679	0	0	0	0	190.01
190.02	1,462	0	0	84	0	190.02
192.00	3,524	11,936	0	1,172	0	192.00
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	577,293	332,846	20,213	44,323	104,999	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141325			Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 3/27/2012 10:30 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT							1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS							4.00
5.00	ADMINISTRATIVE & GENERAL							5.00
7.00	OPERATION OF PLANT							7.00
8.00	LAUNDRY & LINEN SERVICE							8.00
9.00	HOUSEKEEPING							9.00
10.00	DIETARY							10.00
11.00	CAFETERIA	36,086						11.00
13.00	NURSING ADMINISTRATION	0	11,729					13.00
14.00	CENTRAL SERVICES & SUPPLY	258	0	15,225				14.00
15.00	PHARMACY	488	274	0	86,383			15.00
16.00	MEDICAL RECORDS & LIBRARY	2,396	0	0	0	93,248		16.00
17.00	SOCIAL SERVICE	0	0	0	0	0		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	6,033	3,396	789	0	6,166		30.00
31.00	INTENSIVE CARE UNIT	1,442	811	195	0	1,044		31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0	0	0		42.00
43.00	NURSERY	0	0	0	0	0		43.00
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	2,546	1,433	9,250	0	13,695		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0		52.00
53.00	ANESTHESIOLOGY	559	0	0	0	3,115		53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,269	1,839	0	0	5,744		54.00
56.00	RADIOISOTOPE	0	0	0	0	1,646		56.00
56.01	ULTRASOUND	559	315	0	0	2,453		56.01
57.00	CT SCAN	420	236	0	0	10,892		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	2,756		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0		59.00
60.00	LABORATORY	3,268	0	0	0	17,031		60.00
60.01	BLOOD LABORATORY	0	0	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	52	0	0	0	272		62.00
65.00	RESPIRATORY THERAPY	1,081	608	0	0	4,018		65.00
66.00	PHYSICAL THERAPY	2,556	0	0	0	2,478		66.00
67.00	OCCUPATIONAL THERAPY	910	0	0	0	738		67.00
68.00	SPEECH PATHOLOGY	631	0	0	0	260		68.00
69.01	CARDIO-PULMONARY	661	372	0	0	2,459		69.01
69.02	VASCULAR LAB	0	0	0	0	543		69.02
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	145		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	86,383	4,796		73.00
73.01	ONCOLOGY	0	0	0	0	0		73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	4,322	0	826	0	3,890		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0		89.00
91.00	EMERGENCY	4,345	2,445	4,165	0	9,038		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0		96.00
99.10	CORF	0	0	0	0	0		99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS								
109.00	PANCREAS ACQUISITION	0	0	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0	0	0		111.00
116.00	HOSPICE	0	0	0	0	69		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,796	11,729	15,225	86,383	93,248		118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	58	0	0	0	0		190.00
190.01	FOUNDATION	232	0	0	0	0		190.01
190.02	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0		190.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0		192.00
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)	36,086	11,729	15,225	86,383	93,248		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141325

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

Worksheet B
Part II
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	0	945,921	0	945,921	30.00
31.00 INTENSIVE CARE UNIT	0	142,697	0	142,697	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	574,408	0	574,408	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	20,535	0	20,535	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	564,634	0	564,634	54.00
56.00 RADIOISOTOPE	0	18,027	0	18,027	56.00
56.01 ULTRASOUND	0	50,163	0	50,163	56.01
57.00 CT SCAN	0	200,611	0	200,611	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	40,440	0	40,440	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	197,717	0	197,717	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	10,098	0	10,098	62.00
65.00 RESPIRATORY THERAPY	0	36,112	0	36,112	65.00
66.00 PHYSICAL THERAPY	0	170,592	0	170,592	66.00
67.00 OCCUPATIONAL THERAPY	0	28,905	0	28,905	67.00
68.00 SPEECH PATHOLOGY	0	13,115	0	13,115	68.00
69.01 CARDIO-PULMONARY	0	104,579	0	104,579	69.01
69.02 VASCULAR LAB	0	6,652	0	6,652	69.02
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	1,711	0	1,711	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	91,179	0	91,179	73.00
73.01 ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	429,999	0	429,999	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 EMERGENCY	0	406,790	0	406,790	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS					
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
99.10 CORF	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	111.00
116.00 HOSPICE	0	658	0	658	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	4,055,543	0	4,055,543	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,653	0	37,653	190.00
190.01 FOUNDATION	0	6,504	0	6,504	190.01
190.02 DURABLE MEDICAL EQUIP-RENTED	0	1,930	0	1,930	190.02
192.00 PHYSICIANS' PRIVATE OFFICES	0	104,794	0	104,794	192.00
200.00 Cross Foot Adjustments		0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	4,206,424	0	4,206,424	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (MME DEPRE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	96,394					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		1,173,767				2.00
4.00	EMPLOYEE BENEFITS	435	1,310	9,101,585			4.00
5.00	ADMINISTRATIVE & GENERAL	15,267	74,643	1,792,756	-5,410,329	17,235,247	5.00
7.00	OPERATION OF PLANT	8,130	16,728	270,572	0	1,362,746	7.00
8.00	LAUNDRY & LINEN SERVICE	414	0	0	0	131,858	8.00
9.00	HOUSEKEEPING	796	1,898	223,644	0	352,146	9.00
10.00	DIETARY	2,216	12,992	83,752	0	234,642	10.00
11.00	CAFETERIA	756	0	150,473	0	208,440	11.00
13.00	NURSING ADMINISTRATION	288	0	0	0	11,280	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	14,747	24,630	0	65,724	14.00
15.00	PHARMACY	1,361	4,127	78,684	0	881,212	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,883	2,657	283,785	0	486,039	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	18,055	60,429	922,487	0	1,956,968	30.00
31.00	INTENSIVE CARE UNIT	2,552	21,855	223,503	0	410,058	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	9,585	143,275	498,112	0	1,665,738	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	135	8,016	383,409	0	131,922	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,633	389,376	563,131	0	1,477,423	54.00
56.00	RADIOISOTOPE	270	0	0	0	181,502	56.00
56.01	ULTRASOUND	234	40,797	64,927	0	121,066	56.01
57.00	CT SCAN	378	194,106	86,570	0	405,461	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	243,395	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,976	61,983	494,897	0	1,432,575	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	7,884	0	86,335	62.00
65.00	RESPIRATORY THERAPY	558	0	160,840	0	263,854	65.00
66.00	PHYSICAL THERAPY	3,368	11,235	461,899	0	708,964	66.00
67.00	OCCUPATIONAL THERAPY	306	6,004	218,564	0	288,160	67.00
68.00	SPEECH PATHOLOGY	108	1,462	141,010	0	184,041	68.00
69.01	CARDIO-PULMONARY	1,664	35,255	98,412	0	199,739	69.01
69.02	VASCULAR LAB	108	0	0	0	48,531	69.02
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	46,761	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	9,384	10,141	1,069,650	0	1,524,835	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	7,063	54,432	759,465	0	1,813,655	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00	HOSPICE	0	183	387	0	10,956	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	92,877	1,167,651	9,063,443	-5,410,329	16,936,026	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	385	5,407	0	70,363	190.00
190.01	FOUNDATION	0	4,277	32,382	0	79,979	190.01
190.02	DURABLE MEDICAL EQUIP-RENTED	0	463	353	0	43,663	190.02
192.00	PHYSICIANS' PRIVATE OFFICES	2,602	991	0	0	105,216	192.00
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)	3,235,666	970,758	2,038,673		5,410,329	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	33.567089	0.827045	0.223991		0.313911	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			15,685		577,293	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.001723		0.033495	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

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

Worksheet B-1

Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	72,562					7.00
8.00	LAUNDRY & LINEN SERVICE	414	25,281				8.00
9.00	HOUSEKEEPING	796	254	3,177			9.00
10.00	DIETARY	2,216	34	120	2,147		10.00
11.00	CAFETERIA	756	0	0	0	268,358	11.00
13.00	NURSING ADMINISTRATION	288	0	26	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	67	34	0	1,922	14.00
15.00	PHARMACY	1,361	0	45	0	3,626	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,883	0	3	0	17,819	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	18,055	9,816	1,342	1,983	44,861	30.00
31.00	INTENSIVE CARE UNIT	2,552	421	92	164	10,720	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	9,585	2,638	324	0	18,934	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	135	0	0	0	4,160	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,633	1,246	253	0	24,307	54.00
56.00	RADIOISOTOPE	270	0	0	0	0	56.00
56.01	ULTRASOUND	234	0	0	0	4,160	56.01
57.00	CT SCAN	378	0	27	0	3,120	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,976	0	138	0	24,306	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	0	0	387	62.00
65.00	RESPIRATORY THERAPY	558	0	0	0	8,039	65.00
66.00	PHYSICAL THERAPY	3,368	1,306	156	0	19,010	66.00
67.00	OCCUPATIONAL THERAPY	306	0	42	0	6,770	67.00
68.00	SPEECH PATHOLOGY	108	0	35	0	4,689	68.00
69.01	CARDIO-PULMONARY	1,664	1,175	46	0	4,915	69.01
69.02	VASCULAR LAB	108	0	26	0	0	69.02
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
73.01	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	9,384	0	116	0	32,142	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	7,063	8,324	257	0	32,313	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00	HOSPICE	0	0	5	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	69,045	25,281	3,087	2,147	266,200	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	0	0	0	432	190.00
190.01	FOUNDATION	0	0	0	0	1,726	190.01
190.02	DURABLE MEDICAL EQUIP-RENTED	0	0	6	0	0	190.02
192.00	PHYSICIANS' PRIVATE OFFICES	2,602	0	84	0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,790,527	183,466	484,174	381,516	292,527	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	24.675822	7.257071	152.399748	177.697252	1.090063	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	332,846	20,213	44,323	104,999	36,086	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	4.587057	0.799533	13.951212	48.904984	0.134470	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

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

worksheet B-1

Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (TIME SPENT)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
	(NURSING FTE'S)					
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
13.00	154,995					13.00
14.00	0	3,279				14.00
15.00	3,626	0	100			15.00
16.00	0	0	0	46,194,616		16.00
17.00	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	44,861	170	0	3,054,117	0	30.00
31.00	10,720	42	0	517,032	0	31.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
43.00	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	18,934	1,992	0	6,782,857	0	50.00
52.00	0	0	0	0	0	52.00
53.00	0	0	0	1,542,903	0	53.00
54.00	24,307	0	0	2,844,775	0	54.00
56.00	0	0	0	815,282	0	56.00
56.01	4,160	0	0	1,214,807	0	56.01
57.00	3,120	0	0	5,394,902	0	57.00
58.00	0	0	0	1,364,836	0	58.00
59.00	0	0	0	0	0	59.00
60.00	0	0	0	8,445,273	0	60.00
60.01	0	0	0	0	0	60.01
62.00	0	0	0	134,546	0	62.00
65.00	8,039	0	0	1,990,219	0	65.00
66.00	0	0	0	1,227,455	0	66.00
67.00	0	0	0	365,358	0	67.00
68.00	0	0	0	128,901	0	68.00
69.01	4,915	0	0	1,217,739	0	69.01
69.02	0	0	0	268,805	0	69.02
71.00	0	0	0	0	0	71.00
72.00	0	0	0	71,799	0	72.00
73.00	0	0	100	2,375,524	0	73.00
73.01	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	0	178	0	1,926,850	0	88.00
89.00	0	0	0	33	0	89.00
91.00	32,313	897	0	4,476,316	0	91.00
92.00						92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	0	0	0	0	0	96.00
99.10	0	0	0	0	0	99.10
101.00	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	0	0	0	0	0	109.00
110.00	0	0	0	0	0	110.00
111.00	0	0	0	0	0	111.00
116.00	0	0	0	34,287	0	116.00
118.00	154,995	3,279	100	46,194,616	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	0	0	190.00
190.01	0	0	0	0	0	190.01
190.02	0	0	0	0	0	190.02
192.00	0	0	0	0	0	192.00
200.00						200.00
201.00						201.00
202.00	25,890	94,118	1,202,835	704,958	0	202.00
203.00	0.167038	28.703263	12,028.350000	0.015261	0.000000	203.00
204.00	11,729	15,225	86,383	93,248	0	204.00
205.00	0.075673	4.643184	863.830000	0.002019	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

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

Worksheet C
Part I
Date/Time Prepared:
3/27/2012 10:30 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	3,752,814		3,752,814	0	0 30.00
31.00	INTENSIVE CARE UNIT	670,543		670,543	0	0 31.00
41.00	SUBPROVIDER - IRF	0		0	0	0 41.00
42.00	SUBPROVIDER	0		0	0	0 42.00
43.00	NURSERY	0		0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,678,162		2,678,162	0	0 50.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0 52.00
53.00	ANESTHESIOLOGY	204,746		204,746	0	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,177,094		2,177,094	0	0 54.00
56.00	RADIOISOTOPE	257,581		257,581	0	0 56.00
56.01	ULTRASOUND	188,613		188,613	0	0 56.01
57.00	CT SCAN	632,436		632,436	0	0 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	359,727		359,727	0	0 58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	LABORATORY	2,107,426		2,107,426	0	0 60.00
60.01	BLOOD LABORATORY	0		0	0	0 60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	120,354		120,354	0	0 62.00
65.00	RESPIRATORY THERAPY	400,929	0	400,929	0	0 65.00
66.00	PHYSICAL THERAPY	1,087,330	0	1,087,330	0	0 66.00
67.00	OCCUPATIONAL THERAPY	405,525	0	405,525	0	0 67.00
68.00	SPEECH PATHOLOGY	256,890	0	256,890	0	0 68.00
69.01	CARDIO-PULMONARY	343,800		343,800	0	0 69.01
69.02	VASCULAR LAB	74,494		74,494	0	0 69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	62,536		62,536	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	1,239,088		1,239,088	0	0 73.00
73.01	ONCOLOGY	0		0	0	0 73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	2,322,285		2,322,285	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	1		1	0	0 89.00
91.00	EMERGENCY	2,791,521		2,791,521	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	226,805		226,805	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0 96.00
99.10	CORF	0		0	0	0 99.10
101.00	HOME HEALTH AGENCY	0		0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0		0	0	0 109.00
110.00	INTESTINAL ACQUISITION	0		0	0	0 110.00
111.00	ISLET ACQUISITION	0		0	0	0 111.00
116.00	HOSPICE	15,680		15,680	0	0 116.00
200.00	Subtotal (see instructions)	22,376,380	0	22,376,380	0	0 200.00
201.00	Less Observation Beds	226,805		226,805	0	0 201.00
202.00	Total (see instructions)	22,149,575	0	22,149,575	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

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

Worksheet C
Part I
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,899,287		2,899,287		30.00
31.00	INTENSIVE CARE UNIT	517,032		517,032		31.00
41.00	SUBPROVIDER - IRF	0		0		41.00
42.00	SUBPROVIDER	0		0		42.00
43.00	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,316,645	5,466,212	6,782,857	0.394843	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	ANESTHESIOLOGY	376,713	1,166,190	1,542,903	0.132702	53.00
54.00	RADIOLOGY-DIAGNOSTIC	138,157	2,706,618	2,844,775	0.765296	54.00
56.00	RADIOISOTOPE	52,698	762,584	815,282	0.315941	56.00
56.01	ULTRASOUND	41,850	1,172,957	1,214,807	0.155262	56.01
57.00	CT SCAN	224,401	5,170,501	5,394,902	0.117228	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	41,345	1,323,491	1,364,836	0.263568	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	816,909	7,628,364	8,445,273	0.249539	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	55,347	79,199	134,546	0.894519	62.00
65.00	RESPIRATORY THERAPY	1,492,679	497,540	1,990,219	0.201450	65.00
66.00	PHYSICAL THERAPY	253,786	973,669	1,227,455	0.885841	66.00
67.00	OCCUPATIONAL THERAPY	158,331	207,027	365,358	1.109939	67.00
68.00	SPEECH PATHOLOGY	14,980	113,921	128,901	1.992925	68.00
69.01	CARDIO-PULMONARY	755,907	461,832	1,217,739	0.282327	69.01
69.02	VASCULAR LAB	37,025	231,780	268,805	0.277130	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1,092	70,707	71,799	0.870987	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,064,711	1,310,813	2,375,524	0.521606	73.00
73.01	ONCOLOGY	0	0	0	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,926,850	1,926,850		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	EMERGENCY	84,235	4,392,081	4,476,316	0.623620	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	3,780	151,050	154,830	1.464865	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
99.10	CORF	0	0	0		99.10
101.00	HOME HEALTH AGENCY	0	34,287	34,287		101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0		111.00
116.00	HOSPICE	0	0	0		116.00
200.00	Subtotal (see instructions)	10,346,910	35,847,673	46,194,583		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	10,346,910	35,847,673	46,194,583		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

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

Worksheet C
Part I
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	RADIOISOTOPE	0.000000			56.00
56.01	ULTRASOUND	0.000000			56.01
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.01	CARDIO-PULMONARY	0.000000			69.01
69.02	VASCULAR LAB	0.000000			69.02
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
73.01	ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
99.10	CORF				99.10
101.00	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION				109.00
110.00	INTESTINAL ACQUISITION				110.00
111.00	ISLET ACQUISITION				111.00
116.00	HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

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

Worksheet C
Part I
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
			Total Costs	RCE Disallowance	Total Costs	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	3,752,814		3,752,814	0	0	0	30.00
31.00 INTENSIVE CARE UNIT	670,543		670,543	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0		0	0	0	0	41.00
42.00 SUBPROVIDER	0		0	0	0	0	42.00
43.00 NURSERY	0		0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	2,678,162		2,678,162	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
53.00 ANESTHESIOLOGY	204,746		204,746	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,177,094		2,177,094	0	0	0	54.00
56.00 RADIOISOTOPE	257,581		257,581	0	0	0	56.00
56.01 ULTRASOUND	188,613		188,613	0	0	0	56.01
57.00 CT SCAN	632,436		632,436	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	359,727		359,727	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00 LABORATORY	2,107,426		2,107,426	0	0	0	60.00
60.01 BLOOD LABORATORY	0		0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	120,354		120,354	0	0	0	62.00
65.00 RESPIRATORY THERAPY	400,929	0	400,929	0	0	0	65.00
66.00 PHYSICAL THERAPY	1,087,330	0	1,087,330	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	405,525	0	405,525	0	0	0	67.00
68.00 SPEECH PATHOLOGY	256,890	0	256,890	0	0	0	68.00
69.01 CARDIO-PULMONARY	343,800		343,800	0	0	0	69.01
69.02 VASCULAR LAB	74,494		74,494	0	0	0	69.02
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	62,536		62,536	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,239,088		1,239,088	0	0	0	73.00
73.01 ONCOLOGY	0		0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	2,322,285		2,322,285	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	1		1	0	0	0	89.00
91.00 EMERGENCY	2,791,521		2,791,521	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	226,805		226,805	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	0	96.00
99.10 CORF	0		0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0		0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 PANCREAS ACQUISITION	0		0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0		0	0	0	0	110.00
111.00 ISLET ACQUISITION	0		0	0	0	0	111.00
116.00 HOSPICE	15,680		15,680	0	0	0	116.00
200.00 Subtotal (see instructions)	22,376,380	0	22,376,380	0	0	0	200.00
201.00 Less Observation Beds	226,805		226,805	0	0	0	201.00
202.00 Total (see instructions)	22,149,575	0	22,149,575	0	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

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

Worksheet C
Part I
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Title XIX			Hospital	Cost	
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,899,287		2,899,287		30.00
31.00	INTENSIVE CARE UNIT	517,032		517,032		31.00
41.00	SUBPROVIDER - IRF	0		0		41.00
42.00	SUBPROVIDER	0		0		42.00
43.00	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,316,645	5,466,212	6,782,857	0.394843	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	ANESTHESIOLOGY	376,713	1,166,190	1,542,903	0.132702	53.00
54.00	RADIOLOGY-DIAGNOSTIC	138,157	2,706,618	2,844,775	0.765296	54.00
56.00	RADIOISOTOPE	52,698	762,584	815,282	0.315941	56.00
56.01	ULTRASOUND	41,850	1,172,957	1,214,807	0.155262	56.01
57.00	CT SCAN	224,401	5,170,501	5,394,902	0.117228	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	41,345	1,323,491	1,364,836	0.263568	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	816,909	7,628,364	8,445,273	0.249539	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	55,347	79,199	134,546	0.894519	62.00
65.00	RESPIRATORY THERAPY	1,492,679	497,540	1,990,219	0.201450	65.00
66.00	PHYSICAL THERAPY	253,786	973,669	1,227,455	0.885841	66.00
67.00	OCCUPATIONAL THERAPY	158,331	207,027	365,358	1.109939	67.00
68.00	SPEECH PATHOLOGY	14,980	113,921	128,901	1.992925	68.00
69.01	CARDIO-PULMONARY	755,907	461,832	1,217,739	0.282327	69.01
69.02	VASCULAR LAB	37,025	231,780	268,805	0.277130	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1,092	70,707	71,799	0.870987	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,064,711	1,310,813	2,375,524	0.521606	73.00
73.01	ONCOLOGY	0	0	0	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	1,926,850	1,926,850	1.205224	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	EMERGENCY	84,235	4,392,081	4,476,316	0.623620	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	3,780	151,050	154,830	1.464865	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
99.10	CORF	0	0	0		99.10
101.00	HOME HEALTH AGENCY	0	34,287	34,287		101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0		111.00
116.00	HOSPICE	0	0	0		116.00
200.00	Subtotal (see instructions)	10,346,910	35,847,673	46,194,583		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	10,346,910	35,847,673	46,194,583		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

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

Worksheet C
Part I
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	RADIOISOTOPE	0.000000			56.00
56.01	ULTRASOUND	0.000000			56.01
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.01	CARDIO-PULMONARY	0.000000			69.01
69.02	VASCULAR LAB	0.000000			69.02
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
73.01	ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
99.10	CORF				99.10
101.00	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION				109.00
110.00	INTESTINAL ACQUISITION				110.00
111.00	ISLET ACQUISITION				111.00
116.00	HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 141325 Period: From 10/01/2010 To 09/30/2011 Worksheet D Part II Date/Time Prepared: 3/27/2012 10:30 am

Cost Center Description		Title XVIII			Hospital	Cost	
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	574,408	6,782,857	0.084685	644,689	54,595	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	20,535	1,542,903	0.013309	171,735	2,286	53.00
54.00	RADIOLOGY-DIAGNOSTIC	564,634	2,844,775	0.198481	95,286	18,912	54.00
56.00	RADIOISOTOPE	18,027	815,282	0.022111	42,410	938	56.00
56.01	ULTRASOUND	50,163	1,214,807	0.041293	31,192	1,288	56.01
57.00	CT SCAN	200,611	5,394,902	0.037185	142,392	5,295	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	40,440	1,364,836	0.029630	24,647	730	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	197,717	8,445,273	0.023412	576,170	13,489	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,098	134,546	0.075052	51,805	3,888	62.00
65.00	RESPIRATORY THERAPY	36,112	1,990,219	0.018145	1,164,135	21,123	65.00
66.00	PHYSICAL THERAPY	170,592	1,227,455	0.138980	144,179	20,038	66.00
67.00	OCCUPATIONAL THERAPY	28,905	365,358	0.079114	85,211	6,741	67.00
68.00	SPEECH PATHOLOGY	13,115	128,901	0.101745	9,817	999	68.00
69.01	CARDIO-PULMONARY	104,579	1,217,739	0.085880	34,378	2,952	69.01
69.02	VASCULAR LAB	6,652	268,805	0.024747	21,273	526	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1,711	71,799	0.023830	1,092	26	72.00
73.00	DRUGS CHARGED TO PATIENTS	91,179	2,375,524	0.038383	766,254	29,411	73.00
73.01	ONCOLOGY	0	0	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	429,999	1,926,850	0.223162	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	406,790	4,476,316	0.090876	954	87	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	154,830	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	2,966,267	42,743,977		4,007,619	183,324	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325

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

Worksheet D
Part IV
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Title XVIII				Hospital	Cost
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
56.01 ULTRASOUND	0	0	0	0	0	56.01
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.01 CARDIO-PULMONARY	0	0	0	0	0	69.01
69.02 VASCULAR LAB	0	0	0	0	0	69.02
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
73.01 ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325

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

Worksheet D
Part IV
Date/Time Prepared:
3/27/2012 10:30 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	6,782,857	0.000000	0.000000	644,689	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	1,542,903	0.000000	0.000000	171,735	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,844,775	0.000000	0.000000	95,286	54.00
56.00	RADIOISOTOPE	0	815,282	0.000000	0.000000	42,410	56.00
56.01	ULTRASOUND	0	1,214,807	0.000000	0.000000	31,192	56.01
57.00	CT SCAN	0	5,394,902	0.000000	0.000000	142,392	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	1,364,836	0.000000	0.000000	24,647	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	8,445,273	0.000000	0.000000	576,170	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	134,546	0.000000	0.000000	51,805	62.00
65.00	RESPIRATORY THERAPY	0	1,990,219	0.000000	0.000000	1,164,135	65.00
66.00	PHYSICAL THERAPY	0	1,227,455	0.000000	0.000000	144,179	66.00
67.00	OCCUPATIONAL THERAPY	0	365,358	0.000000	0.000000	85,211	67.00
68.00	SPEECH PATHOLOGY	0	128,901	0.000000	0.000000	9,817	68.00
69.01	CARDIO-PULMONARY	0	1,217,739	0.000000	0.000000	34,378	69.01
69.02	VASCULAR LAB	0	268,805	0.000000	0.000000	21,273	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	71,799	0.000000	0.000000	1,092	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,375,524	0.000000	0.000000	766,254	73.00
73.01	ONCOLOGY	0	0	0.000000	0.000000	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	1,926,850	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	4,476,316	0.000000	0.000000	954	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	154,830	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	42,743,977			4,007,619	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325

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

Worksheet D
Part IV
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Title XVIII			Hospital		
	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
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
56.01 ULTRASOUND	0	0	0	0	0	56.01
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.01 CARDIO-PULMONARY	0	0	0	0	0	69.01
69.02 VASCULAR LAB	0	0	0	0	0	69.02
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
73.01 ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325

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

Worksheet D
Part IV
Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	RADIOISOTOPE	0	0			56.00
56.01	ULTRASOUND	0	0			56.01
57.00	CT SCAN	0	0			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	CARDIAC CATHETERIZATION	0	0			59.00
60.00	LABORATORY	0	0			60.00
60.01	BLOOD LABORATORY	0	0			60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
65.00	RESPIRATORY THERAPY	0	0			65.00
66.00	PHYSICAL THERAPY	0	0			66.00
67.00	OCCUPATIONAL THERAPY	0	0			67.00
68.00	SPEECH PATHOLOGY	0	0			68.00
69.01	CARDIO-PULMONARY	0	0			69.01
69.02	VASCULAR LAB	0	0			69.02
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
73.01	ONCOLOGY	0	0			73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0			96.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141325

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

Worksheet D
Part V
Date/Time Prepared:
3/27/2012 10:30 am

		Title XVIII		Hospital		Cost
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			Cost Reimbursed Services 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	0.394843	0	2,524,568	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.132702	0	507,019	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.765296	0	1,061,880	0	54.00
56.00	RADIOISOTOPE	0.315941	0	321,458	0	56.00
56.01	ULTRASOUND	0.155262	0	264,365	0	56.01
57.00	CT SCAN	0.117228	0	2,029,836	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.263568	0	436,624	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.249539	0	3,293,238	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.894519	0	44,183	0	62.00
65.00	RESPIRATORY THERAPY	0.201450	0	334,791	0	65.00
66.00	PHYSICAL THERAPY	0.885841	0	378,210	0	66.00
67.00	OCCUPATIONAL THERAPY	1.109939	0	62,908	0	67.00
68.00	SPEECH PATHOLOGY	1.992925	0	34,177	0	68.00
69.01	CARDIO-PULMONARY	0.282327	0	375,880	0	69.01
69.02	VASCULAR LAB	0.277130	0	137,456	0	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.870987	0	45,997	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.521606	0	771,245	401	73.00
73.01	ONCOLOGY	0.000000	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00	EMERGENCY	0.623620	0	1,298,462	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.464865	0	74,083	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
200.00	Subtotal (see instructions)		0	13,996,380	401	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	13,996,380	401	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/27/2012 10:30 am
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Cost Center Description		Costs			Hospital	Cost
		PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	996,808	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	67,282	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	812,653	0		54.00
56.00	RADIOISOTOPE	0	101,562	0		56.00
56.01	ULTRASOUND	0	41,046	0		56.01
57.00	CT SCAN	0	237,954	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	115,080	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	821,791	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	39,523	0		62.00
65.00	RESPIRATORY THERAPY	0	67,444	0		65.00
66.00	PHYSICAL THERAPY	0	335,034	0		66.00
67.00	OCCUPATIONAL THERAPY	0	69,824	0		67.00
68.00	SPEECH PATHOLOGY	0	68,112	0		68.00
69.01	CARDIO-PULMONARY	0	106,121	0		69.01
69.02	VASCULAR LAB	0	38,093	0		69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	40,063	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	402,286	209		73.00
73.01	ONCOLOGY	0	0	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	EMERGENCY	0	809,747	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	108,522	0		92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Subtotal (see instructions)	0	5,278,945	209		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	5,278,945	209		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/27/2012 10:30 am		
		Component CCN: 14Z325	Title XVIII	Swing Beds - SNF		
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	0.394843	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.132702	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.765296	0	0	0	54.00
56.00	RADIOISOTOPE	0.315941	0	0	0	56.00
56.01	ULTRASOUND	0.155262	0	0	0	56.01
57.00	CT SCAN	0.117228	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.263568	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.249539	0	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.894519	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0.201450	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.885841	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	1.109939	0	0	0	67.00
68.00	SPEECH PATHOLOGY	1.992925	0	0	0	68.00
69.01	CARDIO-PULMONARY	0.282327	0	0	0	69.01
69.02	VASCULAR LAB	0.277130	0	0	0	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.870987	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.521606	0	0	0	73.00
73.01	ONCOLOGY	0.000000	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00	EMERGENCY	0.623620	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.464865	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
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: 141325 Component CCN: 14Z325	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/27/2012 10:30 am
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Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	56.00
56.01	ULTRASOUND	0	0	0	56.01
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.01	CARDIO-PULMONARY	0	0	0	69.01
69.02	VASCULAR LAB	0	0	0	69.02
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
73.01	ONCOLOGY	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	EMERGENCY	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Subtotal (see instructions)	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/27/2012 10:30 am
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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)	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.394843	0	926,341	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.132702	0	382,839	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.765296	0	619,311	0	54.00
56.00 RADIOISOTOPE	0.315941	0	174,628	0	56.00
56.01 ULTRASOUND	0.155262	0	268,389	0	56.01
57.00 CT SCAN	0.117228	0	1,183,081	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.263568	0	302,833	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 LABORATORY	0.249539	0	1,530,486	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.894519	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0.201450	0	266,820	0	65.00
66.00 PHYSICAL THERAPY	0.885841	0	190,268	0	66.00
67.00 OCCUPATIONAL THERAPY	1.109939	0	40,961	0	67.00
68.00 SPEECH PATHOLOGY	1.992925	0	16,664	0	68.00
69.01 CARDIO-PULMONARY	0.282327	0	0	0	69.01
69.02 VASCULAR LAB	0.277130	0	0	0	69.02
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.870987	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.521606	0	181,712	0	73.00
73.01 ONCOLOGY	0.000000	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	1.205224				88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00 EMERGENCY	0.623620	0	2,603,961	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.464865	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
200.00 Subtotal (see instructions)		0	8,688,294	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	8,688,294	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/27/2012 10:30 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	365,759	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	50,804	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	473,956	0	54.00
56.00	RADIOISOTOPE	0	55,172	0	56.00
56.01	ULTRASOUND	0	41,671	0	56.01
57.00	CT SCAN	0	138,690	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	79,817	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	381,916	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	53,751	0	65.00
66.00	PHYSICAL THERAPY	0	168,547	0	66.00
67.00	OCCUPATIONAL THERAPY	0	45,464	0	67.00
68.00	SPEECH PATHOLOGY	0	33,210	0	68.00
69.01	CARDIO-PULMONARY	0	0	0	69.01
69.02	VASCULAR LAB	0	0	0	69.02
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	94,782	0	73.00
73.01	ONCOLOGY	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	EMERGENCY	0	1,623,882	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Subtotal (see instructions)	0	3,607,421	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	3,607,421	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 3/27/2012 10:30 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,516	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,132	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,132	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		79	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)		250	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		17	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		38	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,470	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)		61	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)		268	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		119.75	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.34	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,752,814	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)		2,036	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)		4,687	25.00
26.00	Total swing-bed cost (see instructions)		507,520	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,245,294	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,649,217	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,649,217	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.225001	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,242.60	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,245,294	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)		1,522.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,237,605	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,237,605	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141325

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

worksheet D-1

Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	670,543	164	4,088.68	122	498,819	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						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,475,020	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,211,444	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)					92,853	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					407,944	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					500,797	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)					149	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,522.18	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					226,805	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141325

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

Worksheet D-1

Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	worksheet D-1 Date/Time Prepared: 3/27/2012 10:30 am
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Cost Center Description	Title XIX	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)		2,516	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,132	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,132	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		79	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)		250	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		17	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		38	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		193	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		119.75	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.34	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,752,814	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)		2,036	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)		4,687	25.00
26.00	Total swing-bed cost (see instructions)		507,520	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,245,294	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,649,217	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,649,217	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.225001	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,242.60	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,245,294	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)		1,522.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		293,781	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		293,781	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141325

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

worksheet D-1

Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Title XIX			Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	670,543	164	4,088.68	2	8,177	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)					258,870	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					560,828	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					149	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,522.18	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					226,805	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141325

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

worksheet D-1

Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description	Title XIX		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	Cost
	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)		
	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: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 3/27/2012 10:30 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		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		1,778,881		30.00
31.00	INTENSIVE CARE UNIT		358,965		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.394843	644,689	254,551	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.132702	171,735	22,790	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.765296	95,286	72,922	54.00
56.00	RADIOISOTOPE	0.315941	42,410	13,399	56.00
56.01	ULTRASOUND	0.155262	31,192	4,843	56.01
57.00	CT SCAN	0.117228	142,392	16,692	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.263568	24,647	6,496	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.249539	576,170	143,777	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.894519	51,805	46,341	62.00
65.00	RESPIRATORY THERAPY	0.201450	1,164,135	234,515	65.00
66.00	PHYSICAL THERAPY	0.885841	144,179	127,720	66.00
67.00	OCCUPATIONAL THERAPY	1.109939	85,211	94,579	67.00
68.00	SPEECH PATHOLOGY	1.992925	9,817	19,565	68.00
69.01	CARDIO-PULMONARY	0.282327	34,378	9,706	69.01
69.02	VASCULAR LAB	0.277130	21,273	5,895	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.870987	1,092	951	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.521606	766,254	399,683	73.00
73.01	ONCOLOGY	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.623620	954	595	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.464865	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		4,007,619	1,475,020	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,007,619		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141325	Period: From 10/01/2010	Worksheet D-3
		Component CCN: 14Z325	To 09/30/2011	Date/Time Prepared: 3/27/2012 10:30 am
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost
		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		305,229	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
41.00	SUBPROVIDER - IRF		0	41.00
42.00	SUBPROVIDER		0	42.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.394843	904	357 50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	ANESTHESIOLOGY	0.132702	0	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.765296	3,379	2,586 54.00
56.00	RADIOISOTOPE	0.315941	0	0 56.00
56.01	ULTRASOUND	0.155262	877	136 56.01
57.00	CT SCAN	0.117228	3,108	364 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.263568	0	0 58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	LABORATORY	0.249539	31,574	7,879 60.00
60.01	BLOOD LABORATORY	0.000000	0	0 60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.894519	2,067	1,849 62.00
65.00	RESPIRATORY THERAPY	0.201450	127,755	25,736 65.00
66.00	PHYSICAL THERAPY	0.885841	61,547	54,521 66.00
67.00	OCCUPATIONAL THERAPY	1.109939	44,859	49,791 67.00
68.00	SPEECH PATHOLOGY	1.992925	3,532	7,039 68.00
69.01	CARDIO-PULMONARY	0.282327	314	89 69.01
69.02	VASCULAR LAB	0.277130	1,588	440 69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.870987	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0.521606	75,636	39,452 73.00
73.01	ONCOLOGY	0.000000	0	0 73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
91.00	EMERGENCY	0.623620	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.464865	0	0 92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0 96.00
200.00	Total (sum of lines 50-94 and 96-98)		357,140	190,239 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		357,140	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 3/27/2012 10:30 am	
Cost Center Description		Title XIX	Hospital	Cost	
		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		17,757		30.00
31.00	INTENSIVE CARE UNIT		3,335		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.394843	140,186	55,351	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.132702	69,655	9,243	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.765296	27,285	20,881	54.00
56.00	RADIOISOTOPE	0.315941	10,288	3,250	56.00
56.01	ULTRASOUND	0.155262	8,265	1,283	56.01
57.00	CT SCAN	0.117228	44,317	5,195	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.263568	8,165	2,152	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.249539	105,585	26,348	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.894519	0	0	62.00
65.00	RESPIRATORY THERAPY	0.201450	151,103	30,440	65.00
66.00	PHYSICAL THERAPY	0.885841	0	0	66.00
67.00	OCCUPATIONAL THERAPY	1.109939	0	0	67.00
68.00	SPEECH PATHOLOGY	1.992925	0	0	68.00
69.01	CARDIO-PULMONARY	0.282327	0	0	69.01
69.02	VASCULAR LAB	0.277130	0	0	69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.870987	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.521606	101,209	52,791	73.00
73.01	ONCOLOGY	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	1.205224	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	EMERGENCY	0.623620	83,281	51,936	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.464865	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		749,339	258,870	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		749,339		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	worksheet E Part B Date/Time Prepared: 3/27/2012 10:30 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,279,154 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)			5,279,154 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,331,946 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)			43,572 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,139,913 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)			3,148,461 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)			3,148,461 30.00
31.00	Primary payer payments			13 31.00
32.00	Subtotal (line 30 minus line 31)			3,148,448 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)			550,151 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			550,151 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			471,723 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,698,599 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)			3,698,599 40.00
41.00	Interim payments			3,441,887 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)			256,712 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			101,142 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: 141325

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

Worksheet E
Part B
Date/Time Prepared:
3/27/2012 10:30 am

		Title XVIII	Hospital	Cost	Overrides
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)			0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141325

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

Worksheet E-1
Part I
Date/Time Prepared:
3/27/2012 10:30 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		3,006,874		3,161,167	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	04/08/2011	65,145	04/08/2011	98,875	3.01
3.02		09/16/2011	37,280	09/16/2011	27,521	3.02
3.03		09/30/2011	17,027	09/30/2011	154,324	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)		119,452		280,720	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)		3,126,326		3,441,887	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		847,302		256,712	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,973,628		3,698,599	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: 141325

Period: From 10/01/2010

Worksheet E-1

Component CCN: 14Z325

To 09/30/2011

Part I

Date/Time Prepared: 3/27/2012 10:30 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		583,743		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	04/08/2011	29,016		0	3.01	
3.02		09/16/2011	8,338		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	09/30/2011	42,998		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)		-5,644		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)		578,099		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		117,583		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		695,682		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 FOR HIT

Provider CCN: 141325

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

Worksheet E-1
Part II
Date/Time Prepared:
3/27/2012 10:30 am

		Title XVIII	Hospital	Cost	
				1.00	
DATA COLLECTION NEEDED FOR THE HIT CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from wkst S-3, Part I column 15 line 14			710	1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,592	2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6, line 2			20	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,147	4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200			46,194,583	5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20			4,167,634	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology worksheet S-2, Part I line 168			1,220,283	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,220,283	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment(s)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)			1,220,283	32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141325	Period: From 10/01/2010	Worksheet E-2
		Component CCN:142325	To 09/30/2011	Date/Time Prepared: 3/27/2012 10:30 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)		505,805	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)		192,141	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		329	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)		697,946	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		697,946	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)		697,946	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		2,264	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)		695,682	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)		695,682	0 19.00
20.00	Interim payments		578,099	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)		117,583	0 22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		13,256	0 23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 141325

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

Worksheet E-3
Part V
Date/Time Prepared:
3/27/2012 10:30 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			4,211,444	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)			4,211,444	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			4,253,558	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)			4,253,558	19.00
20.00	Deductibles (exclude professional component)			382,812	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20)			3,870,746	22.00
23.00	Coinsurance			1,650	23.00
24.00	Subtotal (line 22 minus line 23)			3,869,096	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			104,532	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			104,532	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			68,153	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			3,973,628	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)			3,973,628	30.00
31.00	Interim payments			3,126,326	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)			847,302	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			80,768	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 3/27/2012 10:30 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		560,828	1.00
2.00	Medical and other services		3,607,421	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4,168,249	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)		4,168,249	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		40,606	8.00
9.00	Ancillary service charges		9,437,633	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)		9,478,239	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)		9,478,239	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		5,309,990	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)		4,168,249	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.		4,168,249	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)		4,168,249	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)		4,168,249	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		4,168,249	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)		4,168,249	40.00
41.00	Interim payments		1,439,530	41.00
42.00	Balance due provider/program (line 40 minus 41)		2,728,719	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: 141325

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

Worksheet G

Date/Time Prepared:
3/27/2012 10:30 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	8,354,426	0	0	0	1.00
2.00	Temporary investments	5,307,043	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,322,699	0	0	0	4.00
5.00	Other receivable	482,694	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	387,588	0	0	0	7.00
8.00	Prepaid expenses	107,388	0	0	0	8.00
9.00	Other current assets	397,391	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,359,229	0	0	0	11.00
FIXED ASSETS						
12.00	Land	588,318	0	0	0	12.00
13.00	Land improvements	854,467	0	0	0	13.00
14.00	Accumulated depreciation	-274,101	0	0	0	14.00
15.00	Buildings	19,731,423	0	0	0	15.00
16.00	Accumulated depreciation	-3,481,105	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	9,550,462	0	0	0	19.00
20.00	Accumulated depreciation	-1,868,914	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	13,274,609	0	0	0	23.00
24.00	Accumulated depreciation	-9,095,052	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	29,280,107	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	10,508,869	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	801,795	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,310,664	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	58,950,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,099,113	0	0	0	37.00
38.00	Salaries, wages, and fees payable	704,683	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	875,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,722,810	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,401,606	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	28,225,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	28,225,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,626,606	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	26,323,394				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	26,323,394	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	58,950,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141325

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

Worksheet G-1

Date/Time Prepared:
3/27/2012 10:30 am

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
	1.00					
1.00		26,880,604			0	1.00
2.00		-53,344				2.00
3.00		26,827,260			0	3.00
4.00	0		0			4.00
5.00	2,809		0			5.00
6.00	24		0			6.00
7.00	0		0			7.00
8.00	0		0			8.00
9.00	0		0			9.00
10.00		2,833			0	10.00
11.00		26,830,093			0	11.00
12.00	0		0			12.00
13.00	506,699		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		506,699			0	18.00
19.00		26,323,394			0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141325

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

Worksheet G-1

Date/Time Prepared:
3/27/2012 10:30 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141325

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

Worksheet G-2 Parts

Date/Time Prepared:
3/27/2012 10:30 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,649,217		2,649,217	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	355,875		355,875	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)	3,005,092		3,005,092	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	517,770		517,770	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)	517,770		517,770	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,522,862		3,522,862	17.00
18.00	Ancillary services	6,403,406	38,849,136	45,252,542	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,926,850	1,926,850	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		34,287	34,287	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	DIETARY	861	2,739	3,600	27.00
27.01	NURSERY	0	0	0	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	9,927,129	40,813,012	50,740,141	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		25,848,007		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	2,211,834			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		2,211,834		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	GAIN ON DISPOSAL OF ASSETS	0			38.00
39.00	ROUNDING	0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		28,059,841		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141325

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

Worksheet G-3

Date/Time Prepared:
3/27/2012 10:30 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	50,740,141	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,718,231	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,021,910	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	28,059,841	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,037,931	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	756,477	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	16,055	24.00
24.01	OTHER REVENUE	391,501	24.01
24.02	CHANGE IN UNREALIZED GAINS	0	24.02
25.00	Total other income (sum of lines 6-24)	1,164,033	25.00
26.00	Total (line 5 plus line 25)	126,102	26.00
27.00	LOSS ON DISPOSAL OF EQUIPMENT	179,446	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	179,446	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-53,344	29.00

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

Provider CCN: 141325
Component CCN: 143445

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

Worksheet M-1
Date/Time Prepared:
3/27/2012 10:30 am

		Title XVIII		Rural Health Clinic (RHC) I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	537,464	0	537,464	-176,148	361,316	1.00
2.00	Physician Assistant	164,551	0	164,551	0	164,551	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	368,116	0	368,116	481	368,597	9.00
10.00	Subtotal (sum of lines 1-9)	1,070,131	0	1,070,131	-175,667	894,464	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	9,630	9,630	0	9,630	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	79,688	79,688	-21,920	57,768	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	89,318	89,318	-21,920	67,398	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,070,131	89,318	1,159,449	-197,587	961,862	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,070,131	89,318	1,159,449	-197,587	961,862	32.00

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

Provider CCN: 141325

Period: From 10/01/2010

Worksheet M-1

Component CCN: 143445

To 09/30/2011

Date/Time Prepared: 3/27/2012 10:30 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	361,316	1.00
2.00	Physician Assistant	0	164,551	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	368,597	9.00
10.00	Subtotal (sum of lines 1-9)	0	894,464	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	9,630	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	57,768	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	67,398	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	961,862	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	961,862	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet M-2		
		Component CCN: 143445		Date/Time Prepared: 3/27/2012 10:30 am		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.25	5,016	4,200	5,250	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.00	5,294	2,100	4,200	3.00
4.00	Subtotal (sum of lines 1-3)	3.25	10,310		9,450	4.00
5.00	Visiting Nurse	0.00	0			5.00
6.00	Clinical Psychologist	0.00	0			6.00
7.00	Clinical Social Worker	0.00	0			7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	3.25	10,310			8.00
9.00	Physician Services Under Agreements		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)			961,862		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)			961,862		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)			0		14.00
15.00	Parent provider overhead allocated to facility (see instructions)			1,360,423		15.00
16.00	Total overhead (sum of lines 14 and 15)			1,360,423		16.00
17.00	Allowable GME overhead (see instructions)			0		17.00
18.00	Subtract line 17 from line 16			1,360,423		18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)			1,360,423		19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)			2,322,285		20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141325	Period: From 10/01/2010 To 09/30/2011	Worksheet M-3
		Component CCN: 143445		Date/Time Prepared: 3/27/2012 10:30 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)		2,322,285	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)		2,322,285	3.00
4.00	Total Visits (from worksheet M-2, column 5, line 8)		10,310	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)		10,310	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		225.25	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	225.25	225.25	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	231	689	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	52,033	155,197	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) *	52,033	155,197	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.)		114,660	16.04
16.05	Total program cost (see instructions)	41,626	114,660	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,872	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,432	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		156,286	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)		156,286	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)		156,286	26.00
27.00	Interim payments		142,498	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)		13,788	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		3,150	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 141325 Component CCN:143445	Period: From 10/01/2010 To 09/30/2011	Worksheet M-5 Date/Time Prepared: 3/27/2012 10:30 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		125,106	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		04/08/2011	17,392	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)		17,392	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to worksheet M-3, line 27)		142,498	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		13,788	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		156,286	7.00
			Contractor Number	Date (Mo/Day/Yr)
		0	1.00	2.00
8.00	Name of Contractor			8.00