

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: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 12/20/2011 8:00 am
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PART I - COST REPORT STATUS	
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 12/20/2011 Time: 8:00 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 SPARTA COMMUNITY HOSPITAL for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title XVIII		HIT	Title XIX	
	Title V	Part A			
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	128,625	-77,179	0	0
2.00 Subprovider - IPF	0	0	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	-82,213	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
7.00 Skilled Nursing Facility	0	0	0	0	0
8.00 Nursing Facility	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	92,754	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
12.00 CMHC I	0	0	0	0	0
200.00 Total	0	46,412	15,575	0	0

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

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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 12/20/2011 Time: 8:00 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

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Encryption Information
 ECR: Date: 12/20/2011 Time: 8:00 am
 qM4e7fpLM.VLJrZbwMvYQDBY3XVE00
 4I k2S03u4vzzHuVxKufQ1qyo4A8KcD
 Ubo: 00ENZU0ABFW5
 PI: Date: 12/20/2011 Time: 8:00 am
 A12n0szjLYHqlUzplULAI7tn6L8c.01
 SZmmuOLkyZ3.SMSI ezuSG45KuTcYFM
 qBttmbgQI o040boJ

(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	128,625	-77,179	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	-82,213	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	92,754	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	46,412	15,575	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 12/20/2011 7:59 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 818 EAST BROADWAY			PO Box:							
2.00	City: SPARTA			State: IL		Zip Code: 62286		County: RANDOLPH			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SPARTA COMMUNITY HOSPITAL	141349	99914	1	11/01/2005	N	O	N	3.00
4.00	Subprovider - IPF							N	N	N	4.00
5.00	Subprovider - IRF							N	N	N	5.00
6.00	Subprovider - (Other)							N	N	N	6.00
7.00	Swing Beds - SNF		SPARTA COMMUNITY SWING BED	14Z349	99914		11/01/2005	N	O	N	7.00
8.00	Swing Beds - NF							N		N	8.00
9.00	Hospital-Based SNF							N	N	N	9.00
10.00	Hospital-Based NF							N		N	10.00
11.00	Hospital-Based OLTC							N		N	11.00
12.00	Hospital-Based HHA		SPARTA COMMUNITY HHA	147694	99914		08/07/1998	N	P	N	12.00
13.00	Separately Certified ASC							N	N	N	13.00
14.00	Hospital-Based Hospice							N		N	14.00
15.00	Hospital-Based Health Clinic - RHC		WOMEN'S HEALTH CLINIC NORTH CAMPUS	143464	99914		10/06/2004	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FOHC							N	N	N	16.00
17.00	Hospital-Based (CMHC) 1							N	N	N	17.00
17.10	Hospital-Based (CORF) 1							N	N	N	17.10
18.00	Renal Dialysis							N	N	N	18.00
19.00	Other							N	N	N	19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2010	06/30/2011		20.00	
21.00	Type of Control (see instructions)						11		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N		N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0		24.00
25.00	If this provider is an IRF then enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0		25.00
1.00											
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.								2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.								2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0		35.00
							Beginning:	Ending:			
							1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.										36.00
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

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		Beginning:	Ending:			
		1.00	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.	N	N		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		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
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

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		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
				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)			N	0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00

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			V	XIX	
			1.00	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	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		5,000,000		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:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				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: 141349			Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 12/20/2011 7:59 am	
					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 1.00		Part B 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	
156.00	Subprovider - IPF				N		N	
157.00	Subprovider - IRF				N		N	
158.00	Subprovider - Other				N		N	
159.00	SNF				N		N	
160.00	HHA				N		N	
161.00	CMHC				N		N	
							1.00	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	
		Name		County	State	Zip Code	CBSA	FTE/Campus
		0		1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/20/2011 7:59 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Type	Date
			1.00	2.00	3.00
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N	Legal Oper.	
			1.00	2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		
			Description	Y/N	Date
			0	1.00	2.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/08/2011		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/20/2011 7:59 am
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		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	N	2.00	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		Y		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141349

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

Worksheet S-2
Part II
Date/Time Prepared:
12/20/2011 7:59 am

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/08/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part I Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	77,904.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	77,904.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	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	77,904.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		17.00
18.00 SUBPROVIDER	42.00	0	0		18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		19.00
20.00 NURSING FACILITY	45.00	0	0		20.00
21.00 OTHER LONG TERM CARE	46.00	0	0		21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00				23.00
24.00 HOSPICE	116.00	0	0		24.00
25.00 CMHC - CMHC	99.00				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
28.01 SUBPROVIDER - IPF	40.00				28.01
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141349

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

Worksheet S-3
Part I
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	2,340	167	3,229		1.00
2.00 HMO	0	0	0	0		2.00
3.00 HMO IPF	0	0	0	0		3.00
4.00 HMO IRF	0	0	0	0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	738	0	738		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	60		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,078	167	4,027		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT	0	0	0	0		9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0	0		10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0		11.00
12.00 OTHER SPECIAL CARE (SPECIFY)	0	0	0	0		12.00
13.00 NURSERY	0	0	0	0		13.00
14.00 Total (see instructions)	0	3,078	167	4,027		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	0	0	0		16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0		19.00
20.00 NURSING FACILITY	0	0	0	0		20.00
21.00 OTHER LONG TERM CARE	0	0	0	0		21.00
22.00 HOME HEALTH AGENCY	0	4,673	0	5,987		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		23.00
24.00 HOSPICE	0	0	0	0		24.00
25.00 CMHC - CMHC	0	0	0	0		25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	10,485	0	39,063		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)	0	0	0	0		27.00
28.00 Observation Bed Days	0	0	55	416		28.00
28.01 SUBPROVIDER - IPF	0	0	0	0		28.01
28.02 SUBPROVIDER - IRF	0	0	0	0		28.02
28.03 SUBPROVIDER	0	0	0	0		28.03
29.00 Ambulance Trips	0	0	0	0		29.00
30.00 Employee discount days (see instruction)	0	0	0	17		30.00
31.00 Employee discount days - IRF	0	0	0	0		31.00
32.00 Labor & delivery days (see instructions)	0	0	0	0		32.00
33.00 LTCH non-covered days	0	0	0	0		33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part I Date/Time Prepared: 12/20/2011 7:59 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	657	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	194.09	0.00	0	657	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0.00	0.00	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00	0.00	0.00			19.00
20.00 NURSING FACILITY	0.00	0.00	0.00			20.00
21.00 OTHER LONG TERM CARE	0.00	0.00	0.00			21.00
22.00 HOME HEALTH AGENCY	0.00	8.49	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00	0.00	0.00			23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC	0.00	0.00	0.00			25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	48.63	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	251.21	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141349

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

Worksheet S-3
Part I
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	65	972		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)	65	972		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	0	0		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		0		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
28.01 SUBPROVIDER - IPF				28.01
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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet S-4
		Component CCN: 147694		Date/Time Prepared: 12/20/2011 7:59 am
			Home Health Agency I	PPS

		1.00					
0.00	County	RANDOLPH					0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	81	0	0	81	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	239.00	0.00	79.00	318.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00					3.00
4.00	Director(s) and Assistant Director(s)	0.00					4.00
5.00	Other Administrative Personnel	2.53					5.00
6.00	Direct Nursing Service	4.74					6.00
7.00	Nursing Supervisor	0.00					7.00
8.00	Physical Therapy Service	1.05					8.00
9.00	Physical Therapy Supervisor	0.00					9.00
10.00	Occupational Therapy Service	0.00					10.00
11.00	Occupational Therapy Supervisor	0.00					11.00
12.00	Speech Pathology Service	0.00					12.00
13.00	Speech Pathology Supervisor	0.00					13.00
14.00	Medical Social Service	0.00					14.00
15.00	Medical Social Service Supervisor	0.00					15.00
16.00	Home Health Aide	0.17					16.00
17.00	Home Health Aide Supervisor	0.00					17.00
18.00	Other (specify)	0.00					18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.	2					19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	99914					20.00
20.01		41180					20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,509	128	63	94	2,794	21.00
22.00	Skilled Nursing Visit Charges	521,700	29,615	13,997	20,024	585,336	22.00
23.00	Physical Therapy Visits	1,375	16	9	61	1,461	23.00
24.00	Physical Therapy Visit Charges	237,994	2,812	2,235	10,769	253,810	24.00
25.00	Occupational Therapy Visits	238	23	0	10	271	25.00
26.00	Occupational Therapy Visit Charges	39,956	3,714	0	1,654	45,324	26.00
27.00	Speech Pathology Visits	54	20	0	0	74	27.00
28.00	Speech Pathology Visit Charges	11,340	4,200	0	0	15,540	28.00
29.00	Medical Social Service Visits	3	0	0	0	3	29.00
30.00	Medical Social Service Visit Charges	916	0	0	0	916	30.00
31.00	Home Health Aide Visits	61	9	0	0	70	31.00
32.00	Home Health Aide Visit Charges	7,061	1,042	0	0	8,103	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,240	196	72	165	4,673	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	818,967	41,383	16,232	32,447	909,029	35.00
36.00	Total Number of Episodes (standard/non outlier)	284		24	15	323	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	17,484	1,287	230	55	19,056	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141349 Component CCN: 143464	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/20/2011 7:59 am
			Rural Health Clinic (RHC) I	Cost
				1.00
1.00	Clinic Address and Identification Street	1300 NORTH MARKET		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	SPARTA	IL	62286
				1.00
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)		0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00
7.00	Appalachian Regional Commission		0	7.00
8.00	Look-Alikes		0	8.00
9.00	OTHER (SPECIFY)		0	9.00
				1.00
				2.00
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0
				10.00
				1.00
				2.00
				3.00
				4.00
11.00	Facility hours of operations (1) Clinic	13:00	17:00	11:30
				19:00
				1.00
				2.00
12.00	Have you received an approval for an exception to the productivity standard?	N		
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		6
				12.00
				13.00
				1.00
				2.00
14.00	Provider name, CCN number	NORTH CAMPUS		143464
14.01		COULTEVILLE MEDICAL CLINIC		143465
14.02		FAMILY HEALTH CLINIC		143466
14.03		STEELEVILLE CLINIC		143467
14.04		MARISSA MEDICAL CLINIC		143490
14.05		SPARTA MEDICAL OFFICE		143489
		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: 141349 Component CCN: 143464	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/20/2011 7:59 am
			Rural Health Clinic (RHC) I	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	RANDOLPH		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	11:30	19:00	13:00
			19:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141349 Component CCN: 143464		Period: From 07/01/2010 To 06/30/2011		Worksheet S-8 Date/Time Prepared: 12/20/2011 7:59 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	11:30	19:00	11:30	19:00	11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141349 Component CCN: 143464	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 12/20/2011 7:59 am Cost
		Rural Health Clinic (RHC) I	

		Saturday		
		from	to	
11.00	Facility hours of operations (1) Clinic	10:00	15:00	11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 12/20/2011 7:59 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)		0.426495	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		948,170	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,941,436	5.00	
6.00	Medicaid charges		5,668,287	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,417,496	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		13,382	9.00	
10.00	Stand-alone SCHIP charges		58,946	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		25,140	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		11,758	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		31,996	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		11,758	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	779,234	17,718	796,952	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	332,339	7,557	339,896	21.00
22.00	Partial payment by patients approved for charity care	2,375	0	2,375	22.00
23.00	Cost of charity care (line 21 minus line 22)	329,964	7,557	337,521	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,332,102	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		446,495	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,885,607	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		804,202	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,141,723	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,153,481	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet A Date/Time Prepared: 12/20/2011 7:59 am	
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT		769,144	769,144	-6,804	762,340	1.00
1.01 CAP REL COSTS-NORTH CAMPUS BLDG		0	0	211,208	211,208	1.01
2.00 CAP REL COSTS-MVBLE EQUIP		713,542	713,542	17,490	731,032	2.00
3.00 OTHER CAP RELATED COST		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	0	3,084,370	3,084,370	0	3,084,370	4.00
5.00 ADMINISTRATIVE & GENERAL	1,787,535	2,145,541	3,933,076	476,326	4,409,402	5.00
6.00 MAINTENANCE & REPAIRS	217,773	6,237	224,010	0	224,010	6.00
7.00 OPERATION OF PLANT	0	439,005	439,005	0	439,005	7.00
8.00 LAUNDRY & LINEN SERVICE	0	40,610	40,610	0	40,610	8.00
9.00 HOUSEKEEPING	268,258	38,064	306,322	0	306,322	9.00
10.00 DIETARY	228,284	142,714	370,998	0	370,998	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	130,371	1,459	131,830	0	131,830	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	992,089	992,089	0	992,089	15.00
16.00 MEDICAL RECORDS & LIBRARY	133,544	44,478	178,022	75	178,097	16.00
17.00 SOCIAL SERVICE	32,473	801	33,274	0	33,274	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	545,728	545,728	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,206,631	307,526	1,514,157	29	1,514,186	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 SUBPROVIDER - IPF	0	0	0	0	0	40.00
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
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	582,405	405,345	987,750	-169,140	818,610	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	240,878	407,401	648,279	-592,573	55,706	53.00
54.00 RADIOLOGY - DIAGNOSTIC	351,900	151,943	503,843	-88,211	415,632	54.00
54.01 ULTRASOUND	84,013	37,535	121,548	0	121,548	54.01
55.00 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	404,664	404,664	0	404,664	56.00
57.00 CT SCAN	0	317,728	317,728	88,211	405,939	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	397,320	397,320	0	397,320	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	529,998	1,096,558	1,626,556	-33,120	1,593,436	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	49,613	31,815	81,428	0	81,428	65.00
65.01 SLEEP LAB	0	163,200	163,200	0	163,200	65.01
66.00 PHYSICAL THERAPY	485,239	69,644	554,883	-1,277	553,606	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	17,784	10,457	28,241	33,120	61,361	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	169,140	169,140	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	514,201	514,201	0	514,201	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 CARDIAC REHAB	64,131	8,213	72,344	0	72,344	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	2,824,477	1,361,921	4,186,398	-525,654	3,660,744	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet A Date/Time Prepared: 12/20/2011 7:59 am
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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	
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	609,167	1,023,112	1,632,279	0	1,632,279	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	438,836	146,890	585,726	-15,959	569,767	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	175,487	175,487	-175,487	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	10,283,310	15,449,014	25,732,324	-66,898	25,665,426	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	5,935	5,935	0	5,935	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 FREESTANDING CLINICS	1,260,082	23,009	1,283,091	66,898	1,349,989	194.00
194.01 UNUSED SPACE	0	0	0	0	0	194.01
200.00 TOTAL (SUM OF LINES 118-199)	11,543,392	15,477,958	27,021,350	0	27,021,350	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141349

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

Worksheet A
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	-77,426	684,914	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	211,208	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	-1,212	729,820	2.00
3.00	OTHER CAP RELATED COST	0	0	3.00
4.00	EMPLOYEE BENEFITS	-724,952	2,359,418	4.00
5.00	ADMINISTRATIVE & GENERAL	-257,359	4,152,043	5.00
6.00	MAINTENANCE & REPAIRS	0	224,010	6.00
7.00	OPERATION OF PLANT	0	439,005	7.00
8.00	LAUNDRY & LINEN SERVICE	0	40,610	8.00
9.00	HOUSEKEEPING	0	306,322	9.00
10.00	DIETARY	-49,513	321,485	10.00
11.00	CAFETERIA	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	NURSING ADMINISTRATION	0	131,830	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	PHARMACY	0	992,089	15.00
16.00	MEDICAL RECORDS & LIBRARY	-35,423	142,674	16.00
17.00	SOCIAL SERVICE	0	33,274	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	-545,728	0	19.00
20.00	NURSING SCHOOL	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	22.00
23.00	PARAMED. ED. PRGM. -(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-21,108	1,493,078	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	818,610	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	-24,000	31,706	53.00
54.00	RADIOLOGY - DIAGNOSTIC	-4,097	411,535	54.00
54.01	ULTRASOUND	0	121,548	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	404,664	56.00
57.00	CT SCAN	0	405,939	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	397,320	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	1,593,436	60.00
60.01	BLOOD LABORATORY	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	81,428	65.00
65.01	SLEEP LAB	0	163,200	65.01
66.00	PHYSICAL THERAPY	0	553,606	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	61,361	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-39	169,101	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	514,201	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	RENAL DIALYSIS	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	CARDIAC REHAB	0	72,344	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-145,426	3,515,318	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	-588,858	1,043,421	91.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141349

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

Worksheet A
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	6.00	7.00	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	HOME PROGRAM DIALYSIS	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99.00	CMHC	0	0	99.00
99.10	CORF	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	100.00
101.00	HOME HEALTH AGENCY	0	569,767	101.00
SPECIAL PURPOSE COST CENTERS				
105.00	KIDNEY ACQUISITION	0	0	105.00
106.00	HEART ACQUISITION	0	0	106.00
107.00	LIVER ACQUISITION	0	0	107.00
108.00	LUNG ACQUISITION	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	HOSPICE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,475,141	23,190,285	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	5,935	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	FREESTANDING CLINICS	0	1,349,989	194.00
194.01	UNUSED SPACE	0	0	194.01
200.00	TOTAL (SUM OF LINES 118-199)	-2,475,141	24,546,209	200.00

RECLASSIFICATIONS

Provider CCN: 141349

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

Worksheet A-6

Date/Time Prepared:
12/20/2011 7:59 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - TO RECLASS COST OF SUPPLIES SOLD						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	169,140	1.00	
	TOTALS		0	169,140		
B - TO RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	175,314	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	173	2.00	
	TOTALS		0	175,487		
C - TO RECLASS EKG SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	33,120	0	1.00	
	TOTALS		33,120	0		
D - TO RECLASS PROPERTY INSURANCE						
1.00	OTHER CAP RELATED COST	3.00	0	46,580	1.00	
	TOTALS		0	46,580		
E - TO RECLASS TELEPHONE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	33,727	1.00	
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	75	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	29	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	33,831		
F - TO RECLASS ADMINISTRATIVE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	346,218	135,003	1.00	
2.00	FREESTANDING CLINICS	194.00	0	414,470	2.00	
3.00		0.00	0	0	3.00	
	TOTALS		346,218	549,473		
G - TO RECLASS CRNA SALARIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	240,878	304,850	1.00	
	TOTALS		240,878	304,850		
H - TO RECLASS HHA BILLER SALARIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	12,829	0	1.00	
	TOTALS		12,829	0		
I - TO RECLASS NORTH CAMPUS BUILDING						
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	205,783	1.00	
	TOTALS		0	205,783		
J - TO RECLASS CT SCAN SALARIES						
1.00	CT SCAN	57.00	88,211	0	1.00	
	TOTALS		88,211	0		
K - TO RECLASS RHC PHYS. RECRUITMENT EXP						
1.00	RURAL HEALTH CLINIC	88.00	0	5,044	1.00	
	TOTALS		0	5,044		
500.00	Grand Total: Increases		721,256	1,490,188	500.00	

RECLASSIFICATIONS

Provider CCN: 141349

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

Worksheet A-6

Date/Time Prepared:
12/20/2011 7:59 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - TO RECLASS COST OF SUPPLIES SOLD							
1.00	OPERATING ROOM	50.00	0	169,140	0		1.00
	TOTALS		0	169,140			
B - TO RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	175,487	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	175,487			
C - TO RECLASS EKG SALARIES							
1.00	LABORATORY	60.00	33,120	0	0		1.00
	TOTALS		33,120	0			
D - TO RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,580	0		1.00
	TOTALS		0	46,580			
E - TO RECLASS TELEPHONE EXPENSE							
1.00	PHYSICAL THERAPY	66.00	0	1,277	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	28,070	0		2.00
3.00	HOME HEALTH AGENCY	101.00	0	3,130	0		3.00
4.00	FREESTANDING CLINICS	194.00	0	1,354	0		4.00
	TOTALS		0	33,831			
F - TO RECLASS ADMINISTRATIVE EXPENSE							
1.00	ANESTHESIOLOGY	53.00	0	46,845	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	502,628	0		2.00
3.00	FREESTANDING CLINICS	194.00	346,218	0	0		3.00
	TOTALS		346,218	549,473			
G - TO RECLASS CRNA SALARIES							
1.00	ANESTHESIOLOGY	53.00	240,878	304,850	0		1.00
	TOTALS		240,878	304,850			
H - TO RECLASS HHA BILLER SALARIES							
1.00	HOME HEALTH AGENCY	101.00	12,829	0	0		1.00
	TOTALS		12,829	0			
I - TO RECLASS NORTH CAMPUS BUILDING							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	205,783	9		1.00
	TOTALS		0	205,783			
J - TO RECLASS CT SCAN SALARIES							
1.00	RADIOLOGY - DIAGNOSTIC	54.00	88,211	0	0		1.00
	TOTALS		88,211	0			
K - TO RECLASS RHC PHYS. RECRUITMENT EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,044	0		1.00
	TOTALS		0	5,044			
500.00	Grand Total: Decreases		721,256	1,490,188			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141349

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
12/20/2011 7:59 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	85,673	94,161	0	94,161	0	1.00
2.00	Land Improvements	663,393	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,474,711	510,362	0	510,362	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,552,940	522,629	0	522,629	65,981	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,776,717	1,127,152	0	1,127,152	65,981	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,776,717	1,127,152	0	1,127,152	65,981	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	CAP REL COSTS-BLDG & FIXT	769,144	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	713,542	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,482,686	0	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	CAP REL COSTS-BLDG & FIXT	13,543,905	0	13,543,905	0.508060	23,665	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	3,104,561	0	3,104,561	0.116459	5,425	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	10,009,588	0	10,009,588	0.375481	17,490	2.00
3.00	Total (sum of lines 1-2)	26,658,054	0	26,658,054	1.000000	46,580	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141349

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

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	179,834	0			1.00
2.00	Land Improvements	663,393	0			2.00
3.00	Buildings and Fixtures	15,985,073	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	10,009,588	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	26,837,888	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	26,837,888	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	CAP REL COSTS-BLDG & FIXT	0	769,144			1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0			1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	713,542			2.00
3.00	Total (sum of lines 1-2)	0	1,482,686			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	CAP REL COSTS-BLDG & FIXT	0	0	23,665	563,361	0 1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	5,425	205,783	0 1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	17,490	712,330	0 2.00
3.00	Total (sum of lines 1-2)	0	0	46,580	1,481,474	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141349

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
		11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	97,888	23,665	0	0	684,914	1.00	
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	5,425	0	0	211,208	1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	0	17,490	0	0	729,820	2.00	
3.00	Total (sum of lines 1-2)	97,888	46,580	0	0	1,625,942	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 141349

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

Worksheet A-8

Date/Time Prepared:
12/20/2011 7:59 am

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)	B	-77,426	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)	B	-780	ADMINISTRATIVE & GENERAL	5.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)				0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-30,166	ADMINISTRATIVE & GENERAL	5.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)				0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)				0.00 7.00
8.00	Television and radio service (chapter 21)				0.00 8.00
9.00	Parking lot (chapter 21)				0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-783,489		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)				0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0		12.00
13.00	Laundry and linen service				0.00 13.00
14.00	Cafeteria-employees and guests	B	-49,513	DIETARY	10.00 14.00
15.00	Rental of quarters to employee and others				0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-390	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 16.00
17.00	Sale of drugs to other than patients				0.00 17.00
18.00	Sale of medical records and abstracts	B	-35,423	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)				0.00 19.00
20.00	Vending machines				0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)				0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments				0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)			OUTILIZATION REVIEW-SNF	114.00 25.00
26.00	Depreciation - buildings and fixtures			OCAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment			OCAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist	A	-545,728	NONPHYSICIAN ANESTHETISTS	19.00 28.00
29.00	Physicians' assistant				0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest				0.00 32.00
33.00	BILL COPY CHARGES	B	-6,517	ADMINISTRATIVE & GENERAL	5.00 33.00
33.01	MISCELLANEOUS INCOME	B	-165	ADMINISTRATIVE & GENERAL	5.00 33.01
33.02	TRANSMED SERVICE REVENUE	B	-3,389	ADMINISTRATIVE & GENERAL	5.00 33.02
33.03	PHYSICIAN RECRUITMENT COSTS	A	-23,495	ADMINISTRATIVE & GENERAL	5.00 33.03
33.04	PERSONAL USE OF AUTO	A	-17,612	ADMINISTRATIVE & GENERAL	5.00 33.04
33.05	CRNA BENEFITS	A	-26,198	EMPLOYEE BENEFITS	4.00 33.05
33.06	MARKETING SALARY	A	-32,017	ADMINISTRATIVE & GENERAL	5.00 33.06
33.07	MARKETING EXPENSES	A	-109,858	ADMINISTRATIVE & GENERAL	5.00 33.07
33.08	MARKETING EMPLOYEE BENEFITS	A	-9,940	EMPLOYEE BENEFITS	4.00 33.08
33.09	MARKETING CAPITAL EXPENSE	A	-1,212	CAP REL COSTS-MVBLE EQUIP	2.00 33.09
33.10	LOBBYING EXPENSES	A	-9,175	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11	SELF INSURANCE EXPENSE	A	-608,847	EMPLOYEE BENEFITS	4.00 33.11
33.12	VOLUNTARY HOSPITAL CONTRIBUTION	A	-24,079	ADMINISTRATIVE & GENERAL	5.00 33.12
33.13	ALCOHOLIC BEVERAGES	A	-204	ADMINISTRATIVE & GENERAL	5.00 33.13
33.14	FINES & PENALTIES	A	-604	ADMINISTRATIVE & GENERAL	5.00 33.14
33.15	PHYSICIAN EMPLOYEE BENEFITS	A	-28,489	EMPLOYEE BENEFITS	4.00 33.15
33.16	RHC SELF INSURANCE EXPENSE	A	-51,478	EMPLOYEE BENEFITS	4.00 33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,475,141		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141349

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

Worksheet A-8

Date/Time Prepared:
12/20/2011 7:59 am

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	11	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	11	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	BILL COPY CHARGES	0	33.00
33.01	MISCELLANEOUS INCOME	0	33.01
33.02	TRANSMED SERVICE REVENUE	0	33.02
33.03	PHYSICIAN RECRUITMENT COSTS	0	33.03
33.04	PERSONAL USE OF AUTO	0	33.04
33.05	CRNA BENEFITS	0	33.05
33.06	MARKETING SALARY	0	33.06
33.07	MARKETING EXPENSES	0	33.07
33.08	MARKETING EMPLOYEE BENEFITS	0	33.08
33.09	MARKETING CAPITAL EXPENSE	9	33.09
33.10	LOBBYING EXPENSES	0	33.10
33.11	SELF INSURANCE EXPENSE	0	33.11
33.12	VOLUNTARY HOSPITAL CONTRIBUTION	0	33.12
33.13	ALCOHOLIC BEVERAGES	0	33.13
33.14	FINES & PENALTIES	0	33.14
33.15	PHYSICIAN EMPLOYEE BENEFITS	0	33.15
33.16	RHC SELF INSURANCE EXPENSE	0	33.16
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: 141349

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

Worksheet A-8-2

Date/Time Prepared:
12/20/2011 7:59 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	60.00	LABORATORY - PATHOLOGY	22,000	0	1.00
2.00	91.00	EMERGENCY ROOM	888,977	588,858	2.00
3.00	54.00	RADIOLOGIST	4,097	4,097	3.00
4.00	30.00	ADULTS & PEDS	21,108	21,108	4.00
5.00	53.00	ANESTHESIA	24,000	24,000	5.00
6.00	88.00	RURAL HEALTH CLINIC	145,426	145,426	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	1,105,608	783,489	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141349

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

Worksheet A-8-2

Date/Time Prepared:
12/20/2011 7:59 am

	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	22,000	0	0	0	0	1.00
2.00	300,119	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	322,119		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141349

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

Worksheet A-8-2

Date/Time Prepared:
12/20/2011 7:59 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141349

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

Worksheet A-8-2

Date/Time Prepared:
12/20/2011 7:59 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	0	588,858	2.00
3.00	0	4,097	3.00
4.00	0	21,108	4.00
5.00	0	24,000	5.00
6.00	0	145,426	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	783,489	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet A-8-3 Part	
				Physical Therapy		Date/Time Prepared: 12/20/2011 7:59 am	
						Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					8	1.00
2.00	Line 1 multiplied by 15 hours per week					120	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					3	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					293	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	308.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.86	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.43	36.43	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					22,477	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					22,477	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					22,477	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					22,477	23.00
Part III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					109	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					109	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					18	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					127	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					10,674	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					10,674	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					1,714	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet A-8-3 Part	
				Physical Therapy		Date/Time Prepared: 12/20/2011 7:59 am	
						Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.86	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					22,477	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					22,477	63.00
64.00	Total cost of outside supplier services (from your records)					16,914	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					109	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					18	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					127	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					18	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					18	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet A-8-3 Part Date/Time Prepared: 12/20/2011 7:59 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					16	1.00
2.00	Line 1 multiplied by 15 hours per week					240	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					25	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					324	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	432.50	199.50	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.07	51.80	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.54	34.54	25.90			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					29,873	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					10,334	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					40,207	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					40,207	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					40,207	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					864	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					864	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					146	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,010	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					11,191	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					11,191	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					1,895	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet A-8-3 Part Date/Time Prepared: 12/20/2011 7:59 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.07	51.80	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					40,207	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					40,207	63.00
64.00	Total cost of outside supplier services (from your records)					28,563	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					864	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					146	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					1,010	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					146	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					146	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Part Date/Time Prepared: 12/20/2011 7:59 am			
			Speech Pathology	Cost			
			1.00				
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					37	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					58	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.85	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	389.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	66.37	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.19	33.19	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
			1.00				
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					25,835	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					25,835	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					25,835	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					25,835	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					216	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					216	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					1,925	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					1,925	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					339	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet A-8-3 Part	
				Speech Pathology		Date/Time Prepared: 12/20/2011 7:59 am	
						Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.37	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					25,835	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					25,835	63.00
64.00	Total cost of outside supplier services (from your records)					21,570	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					216	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					216	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					216	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					216	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
		BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT	684,914	684,914				1.00
1.01 CAP REL COSTS-NORTH CAMPUS BLDG	211,208	0	211,208			1.01
2.00 CAP REL COSTS-MVBLE EQUIP	729,820			729,820		2.00
4.00 EMPLOYEE BENEFITS	2,359,418	0	0	0	2,359,418	4.00
5.00 ADMINISTRATIVE & GENERAL	4,152,043	86,043	0	104,291	448,459	5.00
6.00 MAINTENANCE & REPAIRS	224,010	16,235	0	348	46,186	6.00
7.00 OPERATION OF PLANT	439,005	39,446	0	51,610	0	7.00
8.00 LAUNDRY & LINEN SERVICE	40,610	7,795	0	0	0	8.00
9.00 HOUSEKEEPING	306,322	6,486	0	1,172	56,892	9.00
10.00 DIETARY	321,485	15,672	0	5,570	48,415	10.00
11.00 CAFETERIA	0	9,422	0	0	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	131,830	5,054	0	416	27,649	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	11,028	0	0	0	14.00
15.00 PHARMACY	992,089	5,176	0	4,316	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	142,674	3,713	0	7,258	28,322	16.00
17.00 SOCIAL SERVICE	33,274	0	0	0	6,887	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,493,078	40,387	0	49,395	255,904	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 SUBPROVIDER - I PF	0	0	0	0	0	40.00
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
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	818,610	69,931	0	152,534	123,517	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	31,706	890	0	18,787	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	411,535	20,848	0	121,043	55,923	54.00
54.01 ULTRASOUND	121,548	4,440	0	24,128	17,818	54.01
55.00 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	404,664	4,757	0	0	0	56.00
57.00 CT SCAN	405,939	3,990	0	498	18,708	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	397,320	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,593,436	16,613	0	40,809	105,378	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	81,428	1,719	0	7,872	10,522	65.00
65.01 SLEEP LAB	163,200	4,297	0	1,465	0	65.01
66.00 PHYSICAL THERAPY	553,606	0	138,407	30,507	102,910	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	61,361	4,910	0	5,572	10,796	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	169,101	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	514,201	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 CARDIAC REHAB	72,344	22,147	0	3,317	13,601	76.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
		BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	3,515,318	157,209	72,801	43,395	568,177	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	1,043,421	38,669	0	17,323	129,193	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	569,767	14,669	0	14,968	90,348	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	23,190,285	611,546	211,208	706,594	2,165,605	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,046	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	5,935	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 FREESTANDING CLINICS	1,349,989	23,631	0	23,226	193,813	194.00
194.01 UNUSED SPACE	0	47,691	0	0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	24,546,209	684,914	211,208	729,820	2,359,418	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4A	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	4,790,836	4,790,836				5.00
6.00	MAINTENANCE & REPAIRS	286,779	69,546	356,325			6.00
7.00	OPERATION OF PLANT	530,061	128,544	17,321	675,926		7.00
8.00	LAUNDRY & LINEN SERVICE	48,405	11,739	3,423	16,186	79,753	8.00
9.00	HOUSEKEEPING	370,872	89,939	2,848	13,467	100	9.00
10.00	DIETARY	391,142	94,855	6,882	32,541	726	10.00
11.00	CAFETERIA	9,422	2,285	4,137	19,563	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	164,949	40,001	2,219	10,493	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	11,028	2,674	4,842	22,898	0	14.00
15.00	PHARMACY	1,001,581	242,891	2,273	10,748	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	181,967	44,128	1,631	7,710	0	16.00
17.00	SOCIAL SERVICE	40,161	9,739	0	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,838,764	445,915	17,734	83,859	41,126	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - I/RF	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
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,164,592	282,423	30,707	145,201	11,378	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	51,383	12,461	391	1,848	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	609,349	147,772	9,155	43,289	3,033	54.00
54.01	ULTRASOUND	167,934	40,725	1,949	9,219	3,560	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	409,421	99,288	2,089	9,877	715	56.00
57.00	CT SCAN	429,135	104,069	1,752	8,284	577	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	397,320	96,353	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,756,236	425,901	7,295	34,495	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	101,541	24,625	755	3,568	0	65.00
65.01	SLEEP LAB	168,962	40,975	1,887	8,921	0	65.01
66.00	PHYSICAL THERAPY	825,430	200,173	65,851	0	7,109	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	82,639	20,041	2,156	10,196	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	169,101	41,008	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	514,201	124,698	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	CARDIAC REHAB	111,409	27,018	9,725	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	4,356,900	1,056,585	103,668	0	427	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,228,606	297,947	16,979	80,290	10,985	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

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

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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4A	5.00	6.00	7.00	8.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	689,752	167,270	6,441	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,899,878	4,391,588	324,110	572,653	79,736	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,046	496	898	4,248	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	5,935	1,439	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	FREESTANDING CLINICS	1,590,659	385,748	10,376	0	17	194.00
194.01	UNUSED SPACE	47,691	11,565	20,941	99,025	0	194.01
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)	24,546,209	4,790,836	356,325	675,926	79,753	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part I Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING	477,226					9.00
10.00	DIETARY	7,842	533,988				10.00
11.00	CAFETERIA	12,295	380,901	428,603			11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	NURSING ADMINISTRATION	0	0	5,923	0	223,585	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	2,873	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	5,860	0	24,826	0	0	16.00
17.00	SOCIAL SERVICE	0	0	5,041	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	193,756	153,087	141,522	0	123,236	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - I/RF	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
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	99,536	0	43,352	0	47,443	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	19,425	0	25,079	0	0	54.00
54.01	ULTRASOUND	2,557	0	8,696	0	0	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	4,435	0	5,671	0	0	56.00
57.00	CT SCAN	3,717	0	4,789	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	34,127	0	55,450	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	5,167	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	862	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	CARDIAC REHAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	21,550	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	85,230	0	59,357	0	52,906	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

Period:
From 07/01/2010
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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	
		9.00	10.00	11.00	12.00	13.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	472,515	533,988	406,423	0	223,585	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	FREESTANDING CLINICS	4,711	0	22,180	0	0	194.00
194.01	UNUSED SPACE	0	0	0	0	0	194.01
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)	477,226	533,988	428,603	0	223,585	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part I Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
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
12.00	MAINTENANCE OF PERSONNEL					12.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY	41,442				14.00
15.00	PHARMACY	0	1,260,366			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	266,122		16.00
17.00	SOCIAL SERVICE	0	0	0	54,941	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
23.00	PARAMED. ED. PRGM. -(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	53,728	54,941	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	SUBPROVIDER - IPF	0	0	0	0	40.00
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
44.00	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	17,761	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	55,504	0	54.00
54.01	ULTRASOUND	0	0	11,841	0	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	12,729	0	56.00
57.00	CT SCAN	0	0	10,657	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	0	36,854	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	1,628	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,442	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,260,366	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	CARDIAC REHAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	31,822	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	0	0	33,598	0	91.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

Period:
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Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
	14.00	15.00	16.00	17.00		
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0		94.00
95.00 AMBULANCE SERVICES	0	0	0	0		95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0		96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0		97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
99.00 CMHC	0	0	0	0		99.00
99.10 CORF	0	0	0	0		99.10
100.00 I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0		100.00
101.00 HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS						
105.00 KIDNEY ACQUISITION	0	0	0	0		105.00
106.00 HEART ACQUISITION	0	0	0	0		106.00
107.00 LIVER ACQUISITION	0	0	0	0		107.00
108.00 LUNG ACQUISITION	0	0	0	0		108.00
109.00 PANCREAS ACQUISITION	0	0	0	0		109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00 ISLET ACQUISITION	0	0	0	0		111.00
113.00 INTEREST EXPENSE	0	0	0	0		113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0		114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116.00 HOSPICE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	41,442	1,260,366	266,122	54,941		118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
191.00 RESEARCH	0	0	0	0		191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00 NONPAID WORKERS	0	0	0	0		193.00
194.00 FREESTANDING CLINICS	0	0	0	0		194.00
194.01 UNUSED SPACE	0	0	0	0		194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	41,442	1,260,366	266,122	54,941		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

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

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Part I
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Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
	(SPECIFY)			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS	
	18.00			19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
1.01 CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
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
12.00 MAINTENANCE OF PERSONNEL						12.00
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						17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0					18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00 NURSING SCHOOL	0	0	0			20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 SUBPROVIDER - 1PF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - 1RF	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
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
54.01 ULTRASOUND	0	0	0	0	0	54.01
55.00 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01 SLEEP LAB	0	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 CARDIAC REHAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

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

Worksheet B
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Cost Center Description	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
	18.00	19.00	20.00	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS	
	21.00	22.00				
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 FREESTANDING CLINICS	0	0	0	0	0	194.00
194.01 UNUSED SPACE	0	0	0	0	0	194.01
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)	0	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	PARAMED. ED. PRGM.	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT					1.00
1.01 CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
6.00 MAINTENANCE & REPAIRS					6.00
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
12.00 MAINTENANCE OF PERSONNEL					12.00
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					17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00 NONPHYSICIAN ANESTHETISTS					19.00
20.00 NURSING SCHOOL					20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00 I&R SERVICES-OTHER PRGM. COSTS APPRVD					22.00
23.00 PARAMED. ED. PRGM.-(SPECIFY)	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	0	3,147,668	0	3,147,668	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00 SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00 SUBPROVIDER - I/RF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	1,842,393	0	1,842,393	50.00
51.00 RECOVERY ROOM	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	66,083	0	66,083	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	912,606	0	912,606	54.00
54.01 ULTRASOUND	0	246,481	0	246,481	54.01
55.00 RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	544,225	0	544,225	56.00
57.00 CT SCAN	0	562,980	0	562,980	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	493,673	0	493,673	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	2,350,358	0	2,350,358	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	135,656	0	135,656	65.00
65.01 SLEEP LAB	0	220,745	0	220,745	65.01
66.00 PHYSICAL THERAPY	0	1,100,191	0	1,100,191	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	115,894	0	115,894	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	251,551	0	251,551	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	638,899	0	638,899	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,260,366	0	1,260,366	73.00
74.00 RENAL DIALYSIS	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00 CARDIAC REHAB	0	148,152	0	148,152	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	5,570,952	0	5,570,952	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141349

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

Worksheet B
Part I
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Cost Center Description		PARAMED. ED. PRGM.	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	0	1,865,898	0	1,865,898	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	99.00
99.10	CORF	0	0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	863,463	0	863,463	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	KIDNEY ACQUISITION	0	0	0	0	105.00
106.00	HEART ACQUISITION	0	0	0	0	106.00
107.00	LIVER ACQUISITION	0	0	0	0	107.00
108.00	LUNG ACQUISITION	0	0	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	22,338,234	0	22,338,234	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	7,688	0	7,688	190.00
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	7,374	0	7,374	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	FREESTANDING CLINICS	0	2,013,691	0	2,013,691	194.00
194.01	UNUSED SPACE	0	179,222	0	179,222	194.01
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	24,546,209	0	24,546,209	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141349

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
		0	1.00	1.01		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	70,220	86,043	0	104,291	260,554 5.00
6.00	MAINTENANCE & REPAIRS	277	16,235	0	348	16,860 6.00
7.00	OPERATION OF PLANT	1,229	39,446	0	51,610	92,285 7.00
8.00	LAUNDRY & LINEN SERVICE	0	7,795	0	0	7,795 8.00
9.00	HOUSEKEEPING	0	6,486	0	1,172	7,658 9.00
10.00	DIETARY	0	15,672	0	5,570	21,242 10.00
11.00	CAFETERIA	0	9,422	0	0	9,422 11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	NURSING ADMINISTRATION	48	5,054	0	416	5,518 13.00
14.00	CENTRAL SERVICES & SUPPLY	0	11,028	0	0	11,028 14.00
15.00	PHARMACY	6,804	5,176	0	4,316	16,296 15.00
16.00	MEDICAL RECORDS & LIBRARY	0	3,713	0	7,258	10,971 16.00
17.00	SOCIAL SERVICE	0	0	0	0	0 17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0 18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0 21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0 22.00
23.00	PARAMED. ED. PRGM. -(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	35,437	40,387	0	49,395	125,219 30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0 40.00
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
44.00	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00	NURSING FACILITY	0	0	0	0	0 45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0 46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,862	69,931	0	152,534	231,327 50.00
51.00	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	ANESTHESIOLOGY	96	890	0	18,787	19,773 53.00
54.00	RADIOLOGY - DIAGNOSTIC	16,848	20,848	0	121,043	158,739 54.00
54.01	ULTRASOUND	44	4,440	0	24,128	28,612 54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0 55.00
56.00	RADIOISOTOPE	0	4,757	0	0	4,757 56.00
57.00	CT SCAN	139,336	3,990	0	498	143,824 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	16,613	0	40,809	57,422 60.00
60.01	BLOOD LABORATORY	0	0	0	0	0 60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0 61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0 62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0 63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	RESPIRATORY THERAPY	15,438	1,719	0	7,872	25,029 65.00
65.01	SLEEP LAB	0	4,297	0	1,465	5,762 65.01
66.00	PHYSICAL THERAPY	0	0	138,407	30,507	168,914 66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	ELECTROCARDIOLOGY	0	4,910	0	5,572	10,482 69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	RENAL DIALYSIS	0	0	0	0	0 74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00	CARDIAC REHAB	0	22,147	0	3,317	25,464 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	4,896	157,209	72,801	43,395	278,301 88.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141349

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

Worksheet B
Part II
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
		1.00	1.01	2.00		
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	38,669	0	17,323	55,992	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	14,669	0	14,968	29,637	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	299,535	611,546	211,208	706,594	1,828,883	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,046	0	0	2,046	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 FREESTANDING CLINICS	481	23,631	0	23,226	47,338	194.00
194.01 UNUSED SPACE	0	47,691	0	0	47,691	194.01
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	300,016	684,914	211,208	729,820	1,925,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet B Part II Date/Time Prepared: 12/20/2011 7:59 am	
Cost Center Description	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE		
	4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0					4.00
5.00	ADMINISTRATIVE & GENERAL	0	260,554				5.00
6.00	MAINTENANCE & REPAIRS	0	3,782	20,642			6.00
7.00	OPERATION OF PLANT	0	6,991	1,003	100,279		7.00
8.00	LAUNDRY & LINEN SERVICE	0	638	198	2,401	11,032	8.00
9.00	HOUSEKEEPING	0	4,891	165	1,998	14	9.00
10.00	DIETARY	0	5,159	399	4,828	100	10.00
11.00	CAFETERIA	0	124	240	2,902	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	2,176	129	1,557	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	145	281	3,397	0	14.00
15.00	PHARMACY	0	13,210	132	1,595	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	2,400	94	1,144	0	16.00
17.00	SOCIAL SERVICE	0	530	0	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	24,251	1,027	12,441	5,690	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - I/RF	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
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	15,360	1,779	21,541	1,574	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	678	23	274	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	8,037	530	6,422	420	54.00
54.01	ULTRASOUND	0	2,215	113	1,368	492	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	5,400	121	1,465	99	56.00
57.00	CT SCAN	0	5,660	101	1,229	80	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	5,240	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	23,163	423	5,118	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	1,339	44	529	0	65.00
65.01	SLEEP LAB	0	2,228	109	1,324	0	65.01
66.00	PHYSICAL THERAPY	0	10,887	3,815	0	983	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	1,090	125	1,513	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,230	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	6,782	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	CARDIAC REHAB	0	1,469	563	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	57,465	6,005	0	59	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	16,204	984	11,912	1,519	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part II Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description		EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	5.00	6.00	7.00	8.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	9,097	373	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	238,841	18,776	84,958	11,030	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	27	52	630	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	78	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	FREESTANDING CLINICS	0	20,979	601	0	2	194.00
194.01	UNUSED SPACE	0	629	1,213	14,691	0	194.01
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)	0	260,554	20,642	100,279	11,032	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141349			Period: From 07/01/2010 To 06/30/2011		Worksheet B Part II Date/Time Prepared: 12/20/2011 7:59 am	
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION		
		9.00	10.00	11.00	12.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG							1.01
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS							4.00
5.00	ADMINISTRATIVE & GENERAL							5.00
6.00	MAINTENANCE & REPAIRS							6.00
7.00	OPERATION OF PLANT							7.00
8.00	LAUNDRY & LINEN SERVICE							8.00
9.00	HOUSEKEEPING	14,726						9.00
10.00	DIETARY	242	31,970					10.00
11.00	CAFETERIA	379	22,805	35,872				11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0			12.00
13.00	NURSING ADMINISTRATION	0	0	496	0	9,876		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0		14.00
15.00	PHARMACY	89	0	0	0	0		15.00
16.00	MEDICAL RECORDS & LIBRARY	181	0	2,078	0	0		16.00
17.00	SOCIAL SERVICE	0	0	422	0	0		17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0		18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0		19.00
20.00	NURSING SCHOOL	0	0	0	0	0		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0		21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0		22.00
23.00	PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	5,979	9,165	11,844	0	5,443		30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0		31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0		32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0		33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0		34.00
40.00	SUBPROVIDER - I/PF	0	0	0	0	0		40.00
41.00	SUBPROVIDER - I/RF	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
44.00	SKILLED NURSING FACILITY	0	0	0	0	0		44.00
45.00	NURSING FACILITY	0	0	0	0	0		45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	3,071	0	3,628	0	2,096		50.00
51.00	RECOVERY ROOM	0	0	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00	RADIOLOGY - DIAGNOSTIC	599	0	2,099	0	0		54.00
54.01	ULTRASOUND	79	0	728	0	0		54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0		55.00
56.00	RADIOISOTOPE	137	0	475	0	0		56.00
57.00	CT SCAN	115	0	401	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0		59.00
60.00	LABORATORY	1,053	0	4,641	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0	0	0		60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0		62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0		63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0	0	432	0	0		65.00
65.01	SLEEP LAB	0	0	0	0	0		65.01
66.00	PHYSICAL THERAPY	0	0	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	27	0	0	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
74.00	RENAL DIALYSIS	0	0	0	0	0		74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0		75.00
76.00	CARDIAC REHAB	0	0	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	0	0	1,804	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0		89.00
90.00	CLINIC	0	0	0	0	0		90.00
91.00	EMERGENCY	2,630	0	4,968	0	2,337		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)							92.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part II Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	
		9.00	10.00	11.00	12.00	13.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,581	31,970	34,016	0	9,876	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	FREESTANDING CLINICS	145	0	1,856	0	0	194.00
194.01	UNUSED SPACE	0	0	0	0	0	194.01
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)	14,726	31,970	35,872	0	9,876	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141349

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

Worksheet B
Part II
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
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
12.00	MAINTENANCE OF PERSONNEL					12.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY	14,851				14.00
15.00	PHARMACY	0	31,322			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	16,868		16.00
17.00	SOCIAL SERVICE	0	0	0	952	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	22.00
23.00	PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	3,405	952	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
40.00	SUBPROVIDER - IPF	0	0	0	0	40.00
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
44.00	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	1,126	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	3,518	0	54.00
54.01	ULTRASOUND	0	0	751	0	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	807	0	56.00
57.00	CT SCAN	0	0	675	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	0	2,336	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	103	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,851	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	31,322	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	CARDIAC REHAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	2,017	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	0	0	2,130	0	91.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141349

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

Worksheet B
Part II
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		14.00	15.00	16.00	17.00		
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0		94.00
95.00	AMBULANCE SERVICES	0	0	0	0		95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0		96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0		97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
99.00	CMHC	0	0	0	0		99.00
99.10	CORF	0	0	0	0		99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0		100.00
101.00	HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
105.00	KIDNEY ACQUISITION	0	0	0	0		105.00
106.00	HEART ACQUISITION	0	0	0	0		106.00
107.00	LIVER ACQUISITION	0	0	0	0		107.00
108.00	LUNG ACQUISITION	0	0	0	0		108.00
109.00	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0	0		111.00
113.00	INTEREST EXPENSE	0	0	0	0		113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0		114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115.00
116.00	HOSPICE	0	0	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,851	31,322	16,868	952		118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
191.00	RESEARCH	0	0	0	0		191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	NONPAID WORKERS	0	0	0	0		193.00
194.00	FREESTANDING CLINICS	0	0	0	0		194.00
194.01	UNUSED SPACE	0	0	0	0		194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	14,851	31,322	16,868	952		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141349

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

Worksheet B
Part II
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
	(SPECIFY)			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS	
	18.00			19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
1.01 CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
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
12.00 MAINTENANCE OF PERSONNEL						12.00
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						17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0					18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0				19.00
20.00 NURSING SCHOOL	0		0			20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0			0		21.00
22.00 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0				0	22.00
23.00 PARAMED. ED. PRGM.-(SPECIFY)	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0					30.00
31.00 INTENSIVE CARE UNIT	0					31.00
32.00 CORONARY CARE UNIT	0					32.00
33.00 BURN INTENSIVE CARE UNIT	0					33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0					34.00
40.00 SUBPROVIDER - 1PF	0					40.00
41.00 SUBPROVIDER - 1RF	0					41.00
42.00 SUBPROVIDER	0					42.00
43.00 NURSERY	0					43.00
44.00 SKILLED NURSING FACILITY	0					44.00
45.00 NURSING FACILITY	0					45.00
46.00 OTHER LONG TERM CARE	0					46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0					50.00
51.00 RECOVERY ROOM	0					51.00
52.00 DELIVERY ROOM & LABOR ROOM	0					52.00
53.00 ANESTHESIOLOGY	0					53.00
54.00 RADIOLOGY - DIAGNOSTIC	0					54.00
54.01 ULTRASOUND	0					54.01
55.00 RADIOLOGY - THERAPEUTIC	0					55.00
56.00 RADIOISOTOPE	0					56.00
57.00 CT SCAN	0					57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
59.00 CARDIAC CATHETERIZATION	0					59.00
60.00 LABORATORY	0					60.00
60.01 BLOOD LABORATORY	0					60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0					61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0					62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0					63.00
64.00 INTRAVENOUS THERAPY	0					64.00
65.00 RESPIRATORY THERAPY	0					65.00
65.01 SLEEP LAB	0					65.01
66.00 PHYSICAL THERAPY	0					66.00
67.00 OCCUPATIONAL THERAPY	0					67.00
68.00 SPEECH PATHOLOGY	0					68.00
69.00 ELECTROCARDIOLOGY	0					69.00
70.00 ELECTROENCEPHALOGRAPHY	0					70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0					72.00
73.00 DRUGS CHARGED TO PATIENTS	0					73.00
74.00 RENAL DIALYSIS	0					74.00
75.00 ASC (NON-DISTINCT PART)	0					75.00
76.00 CARDIAC REHAB	0					76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0					88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0					89.00
90.00 CLINIC	0					90.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141349

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

Worksheet B
Part II
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS				
	18.00			19.00	20.00		21.00	22.00
							SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS
91.00 EMERGENCY	0					91.00		
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00		
OTHER REIMBURSABLE COST CENTERS								
94.00 HOME PROGRAM DIALYSIS	0					94.00		
95.00 AMBULANCE SERVICES	0					95.00		
96.00 DURABLE MEDICAL EQUIP. - RENTED	0					96.00		
97.00 DURABLE MEDICAL EQUIP. - SOLD	0					97.00		
98.00 OTHER REIMBURSABLE COST CENTERS	0					98.00		
99.00 CMHC	0					99.00		
99.10 CORF	0					99.10		
100.00 I&R SERVICES - NOT APPRVD. PRGM.	0					100.00		
101.00 HOME HEALTH AGENCY	0					101.00		
SPECIAL PURPOSE COST CENTERS								
105.00 KIDNEY ACQUISITION	0					105.00		
106.00 HEART ACQUISITION	0					106.00		
107.00 LIVER ACQUISITION	0					107.00		
108.00 LUNG ACQUISITION	0					108.00		
109.00 PANCREAS ACQUISITION	0					109.00		
110.00 INTESTINAL ACQUISITION	0					110.00		
111.00 ISLET ACQUISITION	0					111.00		
113.00 INTEREST EXPENSE	0					113.00		
114.00 UTILIZATION REVIEW-SNF	0					114.00		
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0					115.00		
116.00 HOSPICE	0					116.00		
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0	118.00		
NONREIMBURSABLE COST CENTERS								
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0					190.00		
191.00 RESEARCH	0					191.00		
192.00 PHYSICIANS' PRIVATE OFFICES	0					192.00		
193.00 NONPAID WORKERS	0					193.00		
194.00 FREESTANDING CLINICS	0					194.00		
194.01 UNUSED SPACE	0					194.01		
200.00 Cross Foot Adjustments		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	0	0	0	0	202.00		

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141349

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

Worksheet B
Part II
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description		PARAMED. ED. PRGM.	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
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
12.00	MAINTENANCE OF PERSONNEL					12.00
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					17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00	NONPHYSICIAN ANESTHETISTS					19.00
20.00	NURSING SCHOOL					20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD					22.00
23.00	PARAMED. ED. PRGM.-(SPECIFY)	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		205,416	0	205,416	30.00
31.00	INTENSIVE CARE UNIT		0	0	0	31.00
32.00	CORONARY CARE UNIT		0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT		0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT		0	0	0	34.00
40.00	SUBPROVIDER - I/PF		0	0	0	40.00
41.00	SUBPROVIDER - I/RF		0	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		0	0	0	43.00
44.00	SKILLED NURSING FACILITY		0	0	0	44.00
45.00	NURSING FACILITY		0	0	0	45.00
46.00	OTHER LONG TERM CARE		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		281,502	0	281,502	50.00
51.00	RECOVERY ROOM		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	ANESTHESIOLOGY		20,748	0	20,748	53.00
54.00	RADIOLOGY - DIAGNOSTIC		180,364	0	180,364	54.00
54.01	ULTRASOUND		34,358	0	34,358	54.01
55.00	RADIOLOGY - THERAPEUTIC		0	0	0	55.00
56.00	RADIOISOTOPE		13,261	0	13,261	56.00
57.00	CT SCAN		152,085	0	152,085	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		5,240	0	5,240	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		94,156	0	94,156	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	63.00
64.00	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	RESPIRATORY THERAPY		27,373	0	27,373	65.00
65.01	SLEEP LAB		9,423	0	9,423	65.01
66.00	PHYSICAL THERAPY		184,702	0	184,702	66.00
67.00	OCCUPATIONAL THERAPY		0	0	0	67.00
68.00	SPEECH PATHOLOGY		0	0	0	68.00
69.00	ELECTROCARDIOLOGY		13,237	0	13,237	69.00
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		17,081	0	17,081	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS		6,782	0	6,782	72.00
73.00	DRUGS CHARGED TO PATIENTS		31,322	0	31,322	73.00
74.00	RENAL DIALYSIS		0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)		0	0	0	75.00
76.00	CARDIAC REHAB		27,496	0	27,496	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		345,651	0	345,651	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141349

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

Worksheet B
Part II
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description		PARAMED. ED. PRGM.	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
90.00	CLINIC		0	0	0	90.00
91.00	EMERGENCY		98,676	0	98,676	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS		0	0	0	94.00
95.00	AMBULANCE SERVICES		0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED		0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD		0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
99.00	CMHC		0	0	0	99.00
99.10	CORF		0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.		0	0	0	100.00
101.00	HOME HEALTH AGENCY		39,107	0	39,107	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	KIDNEY ACQUISITION		0	0	0	105.00
106.00	HEART ACQUISITION		0	0	0	106.00
107.00	LIVER ACQUISITION		0	0	0	107.00
108.00	LUNG ACQUISITION		0	0	0	108.00
109.00	PANCREAS ACQUISITION		0	0	0	109.00
110.00	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	ISLET ACQUISITION		0	0	0	111.00
113.00	INTEREST EXPENSE		0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF		0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)		0	0	0	115.00
116.00	HOSPICE		0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,787,980	0	1,787,980	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		2,755	0	2,755	190.00
191.00	RESEARCH		0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES		78	0	78	192.00
193.00	NONPAID WORKERS		0	0	0	193.00
194.00	FREESTANDING CLINICS		70,921	0	70,921	194.00
194.01	UNUSED SPACE		64,224	0	64,224	194.01
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	1,925,958	0	1,925,958	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
	1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	66,953				1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	22,371			1.01
2.00	CAP REL COSTS-MVBLE EQUIP			712,331		2.00
4.00	EMPLOYEE BENEFITS	0	0	0	11,125,071	4.00
5.00	ADMINISTRATIVE & GENERAL	8,411	0	101,792	2,114,565	-4,790,836
6.00	MAINTENANCE & REPAIRS	1,587	0	340	217,773	0
7.00	OPERATION OF PLANT	3,856	0	50,373	0	0
8.00	LAUNDRY & LINEN SERVICE	762	0	0	0	0
9.00	HOUSEKEEPING	634	0	1,144	268,258	0
10.00	DIETARY	1,532	0	5,437	228,284	0
11.00	CAFETERIA	921	0	0	0	0
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	NURSING ADMINISTRATION	494	0	406	130,371	0
14.00	CENTRAL SERVICES & SUPPLY	1,078	0	0	0	0
15.00	PHARMACY	506	0	4,213	0	0
16.00	MEDICAL RECORDS & LIBRARY	363	0	7,084	133,544	0
17.00	SOCIAL SERVICE	0	0	0	32,473	0
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	NURSING SCHOOL	0	0	0	0	0
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0
23.00	PARAMED. ED. PRGM. -(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,948	0	48,211	1,206,631	0
31.00	INTENSIVE CARE UNIT	0	0	0	0	0
32.00	CORONARY CARE UNIT	0	0	0	0	0
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
40.00	SUBPROVIDER - IPF	0	0	0	0	0
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
44.00	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	NURSING FACILITY	0	0	0	0	0
46.00	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,836	0	148,879	582,405	0
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	ANESTHESIOLOGY	87	0	18,337	0	0
54.00	RADIOLOGY - DIAGNOSTIC	2,038	0	118,142	263,689	0
54.01	ULTRASOUND	434	0	23,550	84,013	0
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0
56.00	RADIOISOTOPE	465	0	0	0	0
57.00	CT SCAN	390	0	486	88,211	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	1,624	0	39,831	496,878	0
60.01	BLOOD LABORATORY	0	0	0	0	0
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	168	0	7,683	49,613	0
65.01	SLEEP LAB	420	0	1,430	0	0
66.00	PHYSICAL THERAPY	0	14,660	29,776	485,239	0
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	480	0	5,438	50,904	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	RENAL DIALYSIS	0	0	0	0	0
75.00	ASC (NON-DI STINCT PART)	0	0	0	0	0
76.00	CARDIAC REHAB	2,165	0	3,238	64,131	0
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	15,368	7,711	42,355	2,679,051	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
	1.00	1.01	2.00			
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	3,780	0	16,908	609,167	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	99.00
99.10	CORF	0	0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	1,434	0	14,609	426,007	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	KIDNEY ACQUISITION	0	0	0	0	105.00
106.00	HEART ACQUISITION	0	0	0	0	106.00
107.00	LIVER ACQUISITION	0	0	0	0	107.00
108.00	LUNG ACQUISITION	0	0	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	59,781	22,371	689,662	10,211,207	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	FREESTANDING CLINICS	2,310	0	22,669	913,864	194.00
194.01	UNUSED SPACE	4,662	0	0	0	194.01
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)	684,914	211,208	729,820	2,359,418	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.229773	9.441151	1.024552	0.212081	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
	5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
1.01 CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	19,755,373					5.00
6.00 MAINTENANCE & REPAIRS	286,779	79,326				6.00
7.00 OPERATION OF PLANT	530,061	3,856	31,822			7.00
8.00 LAUNDRY & LINEN SERVICE	48,405	762	762	14,383		8.00
9.00 HOUSEKEEPING	370,872	634	634	18	83,065	9.00
10.00 DIETARY	391,142	1,532	1,532	131	1,365	10.00
11.00 CAFETERIA	9,422	921	921	0	2,140	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	164,949	494	494	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	11,028	1,078	1,078	0	0	14.00
15.00 PHARMACY	1,001,581	506	506	0	500	15.00
16.00 MEDICAL RECORDS & LIBRARY	181,967	363	363	0	1,020	16.00
17.00 SOCIAL SERVICE	40,161	0	0	0	0	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,838,764	3,948	3,948	7,417	33,725	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 SUBPROVIDER - 1PF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - 1RF	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
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,164,592	6,836	6,836	2,052	17,325	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	51,383	87	87	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	609,349	2,038	2,038	547	3,381	54.00
54.01 ULTRASOUND	167,934	434	434	642	445	54.01
55.00 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	409,421	465	465	129	772	56.00
57.00 CT SCAN	429,135	390	390	104	647	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	397,320	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,756,236	1,624	1,624	0	5,940	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	101,541	168	168	0	0	65.00
65.01 SLEEP LAB	168,962	420	420	0	0	65.01
66.00 PHYSICAL THERAPY	825,430	14,660	0	1,282	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	82,639	480	480	0	150	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	169,101	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	514,201	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 CARDIAC REHAB	111,409	2,165	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	4,356,900	23,079	0	77	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.00	6.00	7.00	8.00	9.00	
91.00	EMERGENCY	1,228,606	3,780	3,780	1,981	14,835	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	689,752	1,434	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,109,042	72,154	26,960	14,380	82,245	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,046	200	200	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	5,935	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	FREESTANDING CLINICS	1,590,659	2,310	0	3	820	194.00
194.01	UNUSED SPACE	47,691	4,662	4,662	0	0	194.01
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)	4,790,836	356,325	675,926	79,753	477,226	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.242508	4.491907	21.240840	5.544949	5.745212	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	260,554	20,642	100,279	11,032	14,726	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.013189	0.260217	3.151248	0.767017	0.177283	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	47,076					10.00
11.00	CAFETERIA	33,580	3,401				11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	NURSING ADMINISTRATION	0	47	0	112,388		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	100	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	197	0	0	0	16.00
17.00	SOCIAL SERVICE	0	40	0	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED. ED. PRGM.-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	13,496	1,123	0	61,946	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - I/RF	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
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	344	0	23,848	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	199	0	0	0	54.00
54.01	ULTRASOUND	0	69	0	0	0	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	45	0	0	0	56.00
57.00	CT SCAN	0	38	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	440	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	41	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	100	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	CARDIAC REHAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	171	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	10.00	11.00	12.00	13.00	14.00	
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	471	0	26,594	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	47,076	3,225	0	112,388	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 FREESTANDING CLINICS	0	176	0	0	0	194.00
194.01 UNUSED SPACE	0	0	0	0	0	194.01
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)	533,988	428,603	0	223,585	41,442	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	11.343105	126.022640	0.000000	1.989403	414.420000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	31,970	35,872	0	9,876	14,851	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.679115	10.547486	0.000000	0.087874	148.510000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1
Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
	15.00	16.00	17.00	18.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
1.01						1.01
2.00						2.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00						15.00
16.00	100					15.00
16.00	0	1,798				16.00
17.00	0	0	4,467			17.00
18.00	0	0	0	0		18.00
19.00	0	0	0	0	100	19.00
20.00	0	0	0	0		20.00
21.00	0	0	0	0		21.00
22.00	0	0	0	0		22.00
23.00	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0	363	4,467	0		30.00
31.00	0	0	0	0		31.00
32.00	0	0	0	0		32.00
33.00	0	0	0	0		33.00
34.00	0	0	0	0		34.00
40.00	0	0	0	0		40.00
41.00	0	0	0	0		41.00
42.00	0	0	0	0		42.00
43.00	0	0	0	0		43.00
44.00	0	0	0	0		44.00
45.00	0	0	0	0		45.00
46.00	0	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	120	0	0	0	50.00
51.00	0	0	0	0	0	51.00
52.00	0	0	0	0	0	52.00
53.00	0	0	0	0	100	53.00
54.00	0	375	0	0	0	54.00
54.01	0	80	0	0	0	54.01
55.00	0	0	0	0	0	55.00
56.00	0	86	0	0	0	56.00
57.00	0	72	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	0	249	0	0	0	60.00
60.01	0	0	0	0	0	60.01
61.00	0	0	0	0	0	61.00
62.00	0	0	0	0	0	62.00
63.00	0	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	0	0	0	0	0	65.00
65.01	0	0	0	0	0	65.01
66.00	0	11	0	0	0	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	0	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	0	0	0	71.00
72.00	0	0	0	0	0	72.00
73.00	100	0	0	0	0	73.00
74.00	0	0	0	0	0	74.00
75.00	0	0	0	0	0	75.00
76.00	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	0	215	0	0	0	88.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
	15.00	16.00	17.00	18.00	19.00	
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	227	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
100.00 I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	100	1,798	4,467	0	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 FREESTANDING CLINICS	0	0	0	0	0	194.00
194.01 UNUSED SPACE	0	0	0	0	0	194.01
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)	1,260,366	266,122	54,941	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	12,603.660000	148.010011	12.299306	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	31,322	16,868	952	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	313.220000	9.381535	0.213118	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	INTERNS & RESIDENTS				PARAMED. ED. PRGM. (ASSIGNED TIME)		
	NURSING SCHOOL (ASSIGNED TIME)	SERVICES-SALAR	SERVICES-OTHER	PRGM. COSTS (ASSIGNED TIME)			
		Y & FRINGES (ASSIGNED TIME)					
GENERAL SERVICE COST CENTERS							
1.00							1.00
1.01							1.01
2.00							2.00
4.00							4.00
5.00							5.00
6.00							6.00
7.00							7.00
8.00							8.00
9.00							9.00
10.00							10.00
11.00							11.00
12.00							12.00
13.00							13.00
14.00							14.00
15.00							15.00
16.00							16.00
17.00							17.00
18.00							18.00
19.00							19.00
20.00	0						20.00
21.00		0					21.00
22.00				0			22.00
23.00					0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	0	0	0	0	0		30.00
31.00	0	0	0	0	0		31.00
32.00	0	0	0	0	0		32.00
33.00	0	0	0	0	0		33.00
34.00	0	0	0	0	0		34.00
40.00	0	0	0	0	0		40.00
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
44.00	0	0	0	0	0		44.00
45.00	0	0	0	0	0		45.00
46.00	0	0	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	0	0	0	0	0		50.00
51.00	0	0	0	0	0		51.00
52.00	0	0	0	0	0		52.00
53.00	0	0	0	0	0		53.00
54.00	0	0	0	0	0		54.00
54.01	0	0	0	0	0		54.01
55.00	0	0	0	0	0		55.00
56.00	0	0	0	0	0		56.00
57.00	0	0	0	0	0		57.00
58.00	0	0	0	0	0		58.00
59.00	0	0	0	0	0		59.00
60.00	0	0	0	0	0		60.00
60.01	0	0	0	0	0		60.01
61.00	0	0	0	0	0		61.00
62.00	0	0	0	0	0		62.00
63.00	0	0	0	0	0		63.00
64.00	0	0	0	0	0		64.00
65.00	0	0	0	0	0		65.00
65.01	0	0	0	0	0		65.01
66.00	0	0	0	0	0		66.00
67.00	0	0	0	0	0		67.00
68.00	0	0	0	0	0		68.00
69.00	0	0	0	0	0		69.00
70.00	0	0	0	0	0		70.00
71.00	0	0	0	0	0		71.00
72.00	0	0	0	0	0		72.00
73.00	0	0	0	0	0		73.00
74.00	0	0	0	0	0		74.00
75.00	0	0	0	0	0		75.00
76.00	0	0	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	0	0	0	0	0		88.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141349

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

Worksheet B-1

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED. ED. PRGM. (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)			
		20.00	21.00			
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	99.00
99.10	CORF	0	0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	KIDNEY ACQUISITION	0	0	0	0	105.00
106.00	HEART ACQUISITION	0	0	0	0	106.00
107.00	LIVER ACQUISITION	0	0	0	0	107.00
108.00	LUNG ACQUISITION	0	0	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	FREESTANDING CLINICS	0	0	0	0	194.00
194.01	UNUSED SPACE	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 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		3,147,668	0	0
31.00	INTENSIVE CARE UNIT		0	0	0
32.00	CORONARY CARE UNIT		0	0	0
33.00	BURN INTENSIVE CARE UNIT		0	0	0
34.00	SURGICAL INTENSIVE CARE UNIT		0	0	0
40.00	SUBPROVIDER - 1PF		0	0	0
41.00	SUBPROVIDER - 1RF		0	0	0
42.00	SUBPROVIDER		0	0	0
43.00	NURSERY		0	0	0
44.00	SKILLED NURSING FACILITY		0	0	0
45.00	NURSING FACILITY		0	0	0
46.00	OTHER LONG TERM CARE		0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM		1,842,393	0	0
51.00	RECOVERY ROOM		0	0	0
52.00	DELIVERY ROOM & LABOR ROOM		0	0	0
53.00	ANESTHESIOLOGY		66,083	0	0
54.00	RADIOLOGY - DIAGNOSTIC		912,606	0	0
54.01	ULTRASOUND		246,481	0	0
55.00	RADIOLOGY - THERAPEUTIC		0	0	0
56.00	RADIOISOTOPE		544,225	0	0
57.00	CT SCAN		562,980	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)		493,673	0	0
59.00	CARDIAC CATHETERIZATION		0	0	0
60.00	LABORATORY		2,350,358	0	0
60.01	BLOOD LABORATORY		0	0	0
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0
63.00	BLOOD STORING, PROCESSING, & TRANS.		0	0	0
64.00	INTRAVENOUS THERAPY		0	0	0
65.00	RESPIRATORY THERAPY	0	135,656	0	0
65.01	SLEEP LAB	0	220,745	0	0
66.00	PHYSICAL THERAPY	0	1,100,191	0	0
67.00	OCCUPATIONAL THERAPY	0	0	0	0
68.00	SPEECH PATHOLOGY	0	0	0	0
69.00	ELECTROCARDIOLOGY		115,894	0	0
70.00	ELECTROENCEPHALOGRAPHY		0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		251,551	0	0
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS		638,899	0	0
73.00	DRUGS CHARGED TO PATIENTS		1,260,366	0	0
74.00	RENAL DIALYSIS		0	0	0
75.00	ASC (NON-DISTINCT PART)		0	0	0
76.00	CARDIAC REHAB		148,152	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC		5,570,952	0	0
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0
90.00	CLINIC		0	0	0
91.00	EMERGENCY		1,865,898	0	0
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		298,081	0	0
OTHER REIMBURSABLE COST CENTERS					
94.00	HOME PROGRAM DIALYSIS		0	0	0
95.00	AMBULANCE SERVICES		0	0	0
96.00	DURABLE MEDICAL EQUIP. - RENTED		0	0	0
97.00	DURABLE MEDICAL EQUIP. - SOLD		0	0	0
98.00	OTHER REIMBURSABLE COST CENTERS		0	0	0
99.00	CMHC		0	0	0
99.10	CORF		0	0	0
100.00	I&R SERVICES - NOT APPRVD. PRGM.		0	0	0
101.00	HOME HEALTH AGENCY		863,463	0	0
SPECIAL PURPOSE COST CENTERS					
105.00	KIDNEY ACQUISITION		0	0	0
106.00	HEART ACQUISITION		0	0	0
107.00	LIVER ACQUISITION		0	0	0
108.00	LUNG ACQUISITION		0	0	0
109.00	PANCREAS ACQUISITION		0	0	0
110.00	INTESTINAL ACQUISITION		0	0	0
111.00	ISLET ACQUISITION		0	0	0
113.00	INTEREST EXPENSE		0	0	0
114.00	UTILIZATION REVIEW-SNF		0	0	0

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 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		
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0		0			0	115.00
116.00 HOSPICE	0		0				0
200.00 Subtotal (see instructions)	22,636,315	0	22,636,315	0			0
201.00 Less Observation Beds	298,081		298,081				0
202.00 Total (see instructions)	22,338,234	0	22,338,234	0			0

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am	
			Title XVIII	Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,757,187		1,757,187		30.00
31.00	INTENSIVE CARE UNIT	0		0		31.00
32.00	CORONARY CARE UNIT	0		0		32.00
33.00	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
40.00	SUBPROVIDER - 1PF	0		0		40.00
41.00	SUBPROVIDER - 1RF	0		0		41.00
42.00	SUBPROVIDER	0		0		42.00
43.00	NURSERY	0		0		43.00
44.00	SKILLED NURSING FACILITY	0		0		44.00
45.00	NURSING FACILITY	0		0		45.00
46.00	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	733,867	3,260,699	3,994,566	0.461225	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	ANESTHESIOLOGY	44,429	662,970	707,399	0.093417	53.00
54.00	RADIOLOGY - DIAGNOSTIC	302,535	2,391,093	2,693,628	0.338802	54.00
54.01	ULTRASOUND	282,192	2,016,490	2,298,682	0.107227	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	55.00
56.00	RADIOISOTOPE	127,892	1,332,751	1,460,643	0.372593	56.00
57.00	CT SCAN	731,709	7,494,453	8,226,162	0.068438	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	126,189	2,046,578	2,172,767	0.227209	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	1,384,993	7,350,383	8,735,376	0.269062	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	RESPIRATORY THERAPY	216,489	245,230	461,719	0.293806	65.00
65.01	SLEEP LAB	0	747,747	747,747	0.295213	65.01
66.00	PHYSICAL THERAPY	393,386	3,342,312	3,735,698	0.294507	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	ELECTROCARDIOLOGY	66,735	371,315	438,050	0.264568	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	229,825	527,569	757,394	0.332127	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	450,059	342,150	792,209	0.806478	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,557,207	1,819,395	4,376,602	0.287978	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
76.00	CARDIAC REHAB	0	154,693	154,693	0.957716	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	4,383,441	4,383,441		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0	0.000000	90.00
91.00	EMERGENCY	54,505	3,767,503	3,822,008	0.488198	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	4,205	220,385	224,590	1.327223	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
95.00	AMBULANCE SERVICES	0	0	0	0.000000	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0.000000	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0.000000	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
99.00	CMHC	0	0	0		99.00
99.10	CORF	0	0	0		99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0		100.00
101.00	HOME HEALTH AGENCY	287	1,134,411	1,134,698		101.00
SPECIAL PURPOSE COST CENTERS						
105.00	KIDNEY ACQUISITION	0	0	0		105.00
106.00	HEART ACQUISITION	0	0	0		106.00
107.00	LIVER ACQUISITION	0	0	0		107.00
108.00	LUNG ACQUISITION	0	0	0		108.00
109.00	PANCREAS ACQUISITION	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0		111.00
113.00	INTEREST EXPENSE	0	0	0		113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0		114.00
115.00	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0		115.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
116.00	HOSPICE		0	0	0			116.00
200.00	Subtotal (see instructions)		9,463,691	43,611,568	53,075,259			200.00
201.00	Less Observation Beds							201.00
202.00	Total (see instructions)		9,463,691	43,611,568	53,075,259			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am
Cost Center Description		PPS Inpatient Ratio 11.00	Title XVIII	Hospital
				Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
32.00	CORONARY CARE UNIT			32.00
33.00	BURN INTENSIVE CARE UNIT			33.00
34.00	SURGICAL INTENSIVE CARE UNIT			34.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
45.00	NURSING FACILITY			45.00
46.00	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
51.00	RECOVERY ROOM	0.000000		51.00
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
54.01	ULTRASOUND	0.000000		54.01
55.00	RADIOLOGY - THERAPEUTIC	0.000000		55.00
56.00	RADIOISOTOPE	0.000000		56.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000		63.00
64.00	INTRAVENOUS THERAPY	0.000000		64.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
65.01	SLEEP LAB	0.000000		65.01
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	RENAL DIALYSIS	0.000000		74.00
75.00	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	CARDIAC REHAB	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	HOME PROGRAM DIALYSIS	0.000000		94.00
95.00	AMBULANCE SERVICES	0.000000		95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0.000000		96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0.000000		97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
99.00	CMHC			99.00
99.10	CORF			99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.			100.00
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
105.00	KIDNEY ACQUISITION			105.00
106.00	HEART ACQUISITION			106.00
107.00	LIVER ACQUISITION			107.00
108.00	LUNG ACQUISITION			108.00
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
114.00	UTILIZATION REVIEW-SNF			114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am
		Title XVIII	Hospital	Cost
Cost Center Description		PPS Inpatient Ratio		
		11.00		
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am
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		Title XIX		Hospital		
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		3,147,668	0	0	30.00
31.00	INTENSIVE CARE UNIT		0	0	0	31.00
32.00	CORONARY CARE UNIT		0	0	0	32.00
33.00	BURN INTENSIVE CARE UNIT		0	0	0	33.00
34.00	SURGICAL INTENSIVE CARE UNIT		0	0	0	34.00
40.00	SUBPROVIDER - 1PF		0	0	0	40.00
41.00	SUBPROVIDER - 1RF		0	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		0	0	0	43.00
44.00	SKILLED NURSING FACILITY		0	0	0	44.00
45.00	NURSING FACILITY		0	0	0	45.00
46.00	OTHER LONG TERM CARE		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		1,842,393	0	0	50.00
51.00	RECOVERY ROOM		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	ANESTHESIOLOGY		66,083	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC		912,606	0	0	54.00
54.01	ULTRASOUND		246,481	0	0	54.01
55.00	RADIOLOGY - THERAPEUTIC		0	0	0	55.00
56.00	RADIOISOTOPE		544,225	0	0	56.00
57.00	CT SCAN		562,980	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		493,673	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		2,350,358	0	0	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	63.00
64.00	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	135,656	0	0	65.00
65.01	SLEEP LAB	0	220,745	0	0	65.01
66.00	PHYSICAL THERAPY	0	1,100,191	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY		115,894	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		251,551	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS		638,899	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,260,366	0	0	73.00
74.00	RENAL DIALYSIS		0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)		0	0	0	75.00
76.00	CARDIAC REHAB		148,152	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		5,570,952	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	CLINIC		0	0	0	90.00
91.00	EMERGENCY		1,865,898	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS		0	0	0	94.00
95.00	AMBULANCE SERVICES		0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED		0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD		0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
99.00	CMHC		0	0	0	99.00
99.10	CORF		0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.		0	0	0	100.00
101.00	HOME HEALTH AGENCY		863,463	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00	KIDNEY ACQUISITION		0	0	0	105.00
106.00	HEART ACQUISITION		0	0	0	106.00
107.00	LIVER ACQUISITION		0	0	0	107.00
108.00	LUNG ACQUISITION		0	0	0	108.00
109.00	PANCREAS ACQUISITION		0	0	0	109.00
110.00	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	ISLET ACQUISITION		0	0	0	111.00
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW-SNF					114.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am
	Title XIX	Hospital	

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
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0		0			0	115.00	
116.00 HOSPICE	0		0				0	116.00
200.00 Subtotal (see instructions)	22,338,234	0	22,338,234	0			0	200.00
201.00 Less Observation Beds	0		0				0	201.00
202.00 Total (see instructions)	22,338,234	0	22,338,234	0			0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am	
			Title XIX	Hospital		
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,757,187		1,757,187		30.00
31.00	INTENSIVE CARE UNIT	0		0		31.00
32.00	CORONARY CARE UNIT	0		0		32.00
33.00	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
40.00	SUBPROVIDER - 1 PF	0		0		40.00
41.00	SUBPROVIDER - 1RF	0		0		41.00
42.00	SUBPROVIDER	0		0		42.00
43.00	NURSERY	0		0		43.00
44.00	SKILLED NURSING FACILITY	0		0		44.00
45.00	NURSING FACILITY	0		0		45.00
46.00	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,183,926	3,602,849	4,786,775	0.384892	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	ANESTHESIOLOGY	44,429	662,970	707,399	0.093417	53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,450,516	15,401,365	16,851,881	0.054155	54.00
54.01	ULTRASOUND	0	0	0	0.000000	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	55.00
56.00	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	CT SCAN	0	0	0	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	1,384,993	7,350,383	8,735,376	0.269062	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	RESPIRATORY THERAPY	216,489	245,230	461,719	0.293806	65.00
65.01	SLEEP LAB	0	778,962	778,962	0.283384	65.01
66.00	PHYSICAL THERAPY	393,386	3,342,312	3,735,698	0.294507	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	ELECTROCARDIOLOGY	66,735	340,100	406,835	0.284867	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	229,825	527,569	757,394	0.332127	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,557,208	1,819,395	4,376,603	0.287978	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
76.00	CARDIAC REHAB	0	154,693	154,693	0.957716	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	4,447,788	4,447,788	1.252522	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	CLINIC	0	0	0	0.000000	90.00
91.00	EMERGENCY	54,505	3,767,503	3,822,008	0.488198	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	4,205	220,385	224,590	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
95.00	AMBULANCE SERVICES	0	0	0	0.000000	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0.000000	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0.000000	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
99.00	CMHC	0	0	0	0.000000	99.00
99.10	CORF	0	0	0	0.000000	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0.000000	100.00
101.00	HOME HEALTH AGENCY	277	0	277		101.00
SPECIAL PURPOSE COST CENTERS						
105.00	KIDNEY ACQUISITION	0	0	0		105.00
106.00	HEART ACQUISITION	0	0	0		106.00
107.00	LIVER ACQUISITION	0	0	0		107.00
108.00	LUNG ACQUISITION	0	0	0		108.00
109.00	PANCREAS ACQUISITION	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0		111.00
113.00	INTEREST EXPENSE	0	0	0		113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0		114.00
115.00	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0		115.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am	
			Title XIX		Hospital			
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00	9.00	10.00			
116.00 HOSPICE	0	0	0			116.00		
200.00 Subtotal (see instructions)	9,343,681	42,661,504	52,005,185			200.00		
201.00 Less Observation Beds						201.00		
202.00 Total (see instructions)	9,343,681	42,661,504	52,005,185			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
32.00	CORONARY CARE UNIT				32.00
33.00	BURN INTENSIVE CARE UNIT				33.00
34.00	SURGICAL INTENSIVE CARE UNIT				34.00
40.00	SUBPROVIDER - IPF				40.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
44.00	SKILLED NURSING FACILITY				44.00
45.00	NURSING FACILITY				45.00
46.00	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
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
54.01	ULTRASOUND	0.000000			54.01
55.00	RADIOLOGY - THERAPEUTIC	0.000000			55.00
56.00	RADIOISOTOPE	0.000000			56.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000			61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
65.01	SLEEP LAB	0.000000			65.01
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	RENAL DIALYSIS	0.000000			74.00
75.00	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	CARDIAC REHAB	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	HOME PROGRAM DIALYSIS	0.000000			94.00
95.00	AMBULANCE SERVICES	0.000000			95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0.000000			96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0.000000			97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
99.00	CMHC				99.00
99.10	CORF				99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.				100.00
101.00	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
105.00	KIDNEY ACQUISITION				105.00
106.00	HEART ACQUISITION				106.00
107.00	LIVER ACQUISITION				107.00
108.00	LUNG ACQUISITION				108.00
109.00	PANCREAS ACQUISITION				109.00
110.00	INTESTINAL ACQUISITION				110.00
111.00	ISLET ACQUISITION				111.00
113.00	INTEREST EXPENSE				113.00
114.00	UTILIZATION REVIEW-SNF				114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)				115.00
116.00	HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/20/2011 7:59 am
		Title XIX	Hospital	
Cost Center Description		PPS Inpatient Ratio		
		11.00		
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part II Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description		Title XIX Hospital					
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,842,393	281,502	1,560,891	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	66,083	20,748	45,335	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	912,606	180,364	732,242	0	0	54.00
54.01	ULTRASOUND	246,481	34,358	212,123	0	0	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	544,225	13,261	530,964	0	0	56.00
57.00	CT SCAN	562,980	152,085	410,895	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	493,673	5,240	488,433	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	2,350,358	94,156	2,256,202	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	135,656	27,373	108,283	0	0	65.00
65.01	SLEEP LAB	220,745	9,423	211,322	0	0	65.01
66.00	PHYSICAL THERAPY	1,100,191	184,702	915,489	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	115,894	13,237	102,657	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	251,551	17,081	234,470	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	638,899	6,782	632,117	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,260,366	31,322	1,229,044	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	CARDIAC REHAB	148,152	27,496	120,656	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	5,570,952	345,651	5,225,301	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,865,898	98,676	1,767,222	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0	0	0	100.00
101.00	HOME HEALTH AGENCY	863,463	39,107	824,356	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105.00	KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00	HEART ACQUISITION	0	0	0	0	0	106.00
107.00	LIVER ACQUISITION	0	0	0	0	0	107.00
108.00	LUNG ACQUISITION	0	0	0	0	0	108.00
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	19,190,566	1,582,564	17,608,002	0	0	200.00
201.00	Less Observation Beds	0	0	0	0	0	201.00
202.00	Total (line 200 minus line 201)	19,190,566	1,582,564	17,608,002	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part II Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,842,393	3,994,566	0.461225		50.00
51.00	RECOVERY ROOM	0	0	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	ANESTHESIOLOGY	66,083	707,399	0.093417		53.00
54.00	RADIOLOGY - DIAGNOSTIC	912,606	2,693,628	0.338802		54.00
54.01	ULTRASOUND	246,481	2,298,682	0.107227		54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0.000000		55.00
56.00	RADIOISOTOPE	544,225	1,460,643	0.372593		56.00
57.00	CT SCAN	562,980	8,226,162	0.068438		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	493,673	2,172,767	0.227209		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	LABORATORY	2,350,358	8,735,376	0.269062		60.00
60.01	BLOOD LABORATORY	0	0	0.000000		60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0.000000		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000		62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000		63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	RESPIRATORY THERAPY	135,656	461,719	0.293806		65.00
65.01	SLEEP LAB	220,745	747,747	0.295213		65.01
66.00	PHYSICAL THERAPY	1,100,191	3,735,698	0.294507		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	ELECTROCARDIOLOGY	115,894	438,050	0.264568		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	251,551	757,394	0.332127		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	638,899	792,209	0.806478		72.00
73.00	DRUGS CHARGED TO PATIENTS	1,260,366	4,376,602	0.287978		73.00
74.00	RENAL DIALYSIS	0	0	0.000000		74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
76.00	CARDIAC REHAB	148,152	154,693	0.957716		76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	5,570,952	4,383,441	1.270908		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	CLINIC	0	0	0.000000		90.00
91.00	EMERGENCY	1,865,898	3,822,008	0.488198		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	224,590	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
95.00	AMBULANCE SERVICES	0	0	0.000000		95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0.000000		96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0.000000		97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000		98.00
99.00	CMHC	0	0	0.000000		99.00
99.10	CORF	0	0	0.000000		99.10
100.00	I&R SERVICES - NOT APPRVD. PRGM.	0	0	0.000000		100.00
101.00	HOME HEALTH AGENCY	863,463	1,134,698	0.760963		101.00
SPECIAL PURPOSE COST CENTERS						
105.00	KIDNEY ACQUISITION	0	0	0.000000		105.00
106.00	HEART ACQUISITION	0	0	0.000000		106.00
107.00	LIVER ACQUISITION	0	0	0.000000		107.00
108.00	LUNG ACQUISITION	0	0	0.000000		108.00
109.00	PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	ISLET ACQUISITION	0	0	0.000000		111.00
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW-SNF					114.00
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0.000000		115.00
116.00	HOSPICE	0	0	0.000000		116.00
200.00	Subtotal (sum of lines 50 thru 199)	19,190,566	0			200.00
201.00	Less Observation Beds	0	0			201.00
202.00	Total (line 200 minus line 201)	19,190,566	51,318,072			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	281,502	3,994,566	0.070471	405,026	28,543	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	20,748	707,399	0.029330	18,878	554	53.00
54.00	RADIOLOGY - DIAGNOSTIC	180,364	2,693,628	0.066960	242,911	16,265	54.00
54.01	ULTRASOUND	34,358	2,298,682	0.014947	78,428	1,172	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	RADIOISOTOPE	13,261	1,460,643	0.009079	82,436	748	56.00
57.00	CT SCAN	152,085	8,226,162	0.018488	515,392	9,529	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	5,240	2,172,767	0.002412	60,237	145	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	94,156	8,735,376	0.010779	939,599	10,128	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	27,373	461,719	0.059285	139,984	8,299	65.00
65.01	SLEEP LAB	9,423	747,747	0.012602	0	0	65.01
66.00	PHYSICAL THERAPY	184,702	3,735,698	0.049442	145,065	7,172	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	13,237	438,050	0.030218	46,945	1,419	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,081	757,394	0.022552	163,037	3,677	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,782	792,209	0.008561	307,181	2,630	72.00
73.00	DRUGS CHARGED TO PATIENTS	31,322	4,376,602	0.007157	1,575,800	11,278	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	CARDIAC REHAB	27,496	154,693	0.177746	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	345,651	4,383,441	0.078854	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	98,676	3,822,008	0.025818	9,659	249	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	224,590	0.000000	170	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0.000000	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0.000000	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	1,543,457	50,183,374		4,730,748	101,808	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
54.01	ULTRASOUND	0	0	0	0	0	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	CARDIAC REHAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
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: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/20/2011 7:59 am
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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	3,994,566	0.000000	0.000000	405,026	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	707,399	0.000000	0.000000	18,878	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	2,693,628	0.000000	0.000000	242,911	54.00
54.01	ULTRASOUND	0	2,298,682	0.000000	0.000000	78,428	54.01
55.00	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	RADIOISOTOPE	0	1,460,643	0.000000	0.000000	82,436	56.00
57.00	CT SCAN	0	8,226,162	0.000000	0.000000	515,392	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	2,172,767	0.000000	0.000000	60,237	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	8,735,376	0.000000	0.000000	939,599	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0.000000	0.000000	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	461,719	0.000000	0.000000	139,984	65.00
65.01	SLEEP LAB	0	747,747	0.000000	0.000000	0	65.01
66.00	PHYSICAL THERAPY	0	3,735,698	0.000000	0.000000	145,065	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	438,050	0.000000	0.000000	46,945	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	757,394	0.000000	0.000000	163,037	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	792,209	0.000000	0.000000	307,181	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,376,602	0.000000	0.000000	1,575,800	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	CARDIAC REHAB	0	154,693	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	4,383,441	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	3,822,008	0.000000	0.000000	9,659	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	224,590	0.000000	0.000000	170	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
95.00	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0	0	0.000000	0.000000	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0	0	0.000000	0.000000	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	50,183,374			4,730,748	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/20/2011 7:59 am
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Cost Center Description	Title XVIII			Hospital	Cost		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01 ULTRASOUND	0	0	0	0	0	0	54.01
55.00 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY							61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
65.01 SLEEP LAB	0	0	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
76.00 CARDIAC REHAB	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00 HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
95.00 AMBULANCE SERVICES							95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00 Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/20/2011 7:59 am
	Title XVIII	Hospital	Cost

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0		50.00
51.00 RECOVERY ROOM	0	0		51.00
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
54.01 ULTRASOUND	0	0		54.01
55.00 RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00 RADIOISOTOPE	0	0		56.00
57.00 CT SCAN	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0		59.00
60.00 LABORATORY	0	0		60.00
60.01 BLOOD LABORATORY	0	0		60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0		65.00
65.01 SLEEP LAB	0	0		65.01
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 RENAL DIALYSIS	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 CARDIAC REHAB	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 CLINIC	0	0		90.00
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 HOME PROGRAM DIALYSIS	0	0		94.00
95.00 AMBULANCE SERVICES	0	0		95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0		96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0		97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/20/2011 7:59 am
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		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	0.461225	0	873,595	0		50.00
51.00	RECOVERY ROOM	0.000000	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.093417	0	26,686	0		53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.338802	0	1,480,104	0		54.00
54.01	ULTRASOUND	0.107227	0	194,665	0		54.01
55.00	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0		55.00
56.00	RADIOISOTOPE	0.372593	0	674,584	0		56.00
57.00	CT SCAN	0.068438	0	2,595,629	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.227209	0	499,923	0		58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00	LABORATORY	0.269062	0	3,296,700	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0		62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0		63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0.293806	0	114,838	0		65.00
65.01	SLEEP LAB	0.295213	0	178,885	0		65.01
66.00	PHYSICAL THERAPY	0.294507	0	1,140,635	0		66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0.264568	0	163,666	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.332127	0	222,776	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.806478	0	153,146	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.287978	0	1,027,537	9,247		73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0		74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0		75.00
76.00	CARDIAC REHAB	0.957716	0	101,553	0		76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0.000000					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	0.000000	0	0	0		90.00
91.00	EMERGENCY	0.488198	0	927,490	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.327223	0	109,965	0		92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	HOME PROGRAM DIALYSIS	0.000000		0			94.00
95.00	AMBULANCE SERVICES	0.000000		0			95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0.000000	0	0	0		96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0.000000	0	0	0		97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0		98.00
200.00	Subtotal (see instructions)		0	13,782,377	9,247		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	13,782,377	9,247		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/20/2011 7:59 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	
	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	402,924	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	2,493	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	501,462	0	54.00
54.01 ULTRASOUND	0	20,873	0	54.01
55.00 RADIOLOGY - THERAPEUTIC	0	0	0	55.00
56.00 RADIOISOTOPE	0	251,345	0	56.00
57.00 CT SCAN	0	177,640	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	113,587	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	887,017	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	33,740	0	65.00
65.01 SLEEP LAB	0	52,809	0	65.01
66.00 PHYSICAL THERAPY	0	335,925	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	43,301	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	73,990	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	123,509	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	295,908	2,663	73.00
74.00 RENAL DIALYSIS	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00 CARDIAC REHAB	0	97,259	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	0	0	0	90.00
91.00 EMERGENCY	0	452,799	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	145,948	0	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 HOME PROGRAM DIALYSIS		0	0	94.00
95.00 AMBULANCE SERVICES		0	0	95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0	96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0	97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00 Subtotal (see instructions)	0	4,012,529	2,663	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	4,012,529	2,663	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/20/2011 7:59 am		
		Component CCN: 14Z349	Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.461225	0	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.093417	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.338802	0	0	0	54.00
54.01	ULTRASOUND	0.107227	0	0	0	54.01
55.00	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	55.00
56.00	RADIOISOTOPE	0.372593	0	0	0	56.00
57.00	CT SCAN	0.068438	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.227209	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.269062	0	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.293806	0	0	0	65.00
65.01	SLEEP LAB	0.295213	0	0	0	65.01
66.00	PHYSICAL THERAPY	0.294507	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.264568	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.332127	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.806478	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.287978	0	0	0	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
76.00	CARDIAC REHAB	0.957716	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	CLINIC	0.000000	0	0	0	90.00
91.00	EMERGENCY	0.488198	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.327223	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	HOME PROGRAM DIALYSIS	0.000000		0		94.00
95.00	AMBULANCE SERVICES	0.000000		0		95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0.000000	0	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0.000000	0	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
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: 141349 Component CCN: 14Z349	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/20/2011 7:59 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
54.01 ULTRASOUND	0	0	0		54.01
55.00 RADIOLOGY - THERAPEUTIC	0	0	0		55.00
56.00 RADIOISOTOPE	0	0	0		56.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0			61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
65.01 SLEEP LAB	0	0	0		65.01
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00 CARDIAC REHAB	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00 HOME PROGRAM DIALYSIS		0	0		94.00
95.00 AMBULANCE SERVICES		0			95.00
96.00 DURABLE MEDICAL EQUIP. - RENTED	0	0	0		96.00
97.00 DURABLE MEDICAL EQUIP. - SOLD	0	0	0		97.00
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 12/20/2011 7:59 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)		4,443	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,645	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,645	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		384	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)		354	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		15	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)		45	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,340	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)		384	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)		354	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		117.79	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		117.79	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,147,668	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)		1,767	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)		5,301	25.00
26.00	Total swing-bed cost (see instructions)		535,875	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,611,793	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,839,090	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,839,090	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.420155	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)		504.55	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,611,793	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)		716.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,676,704	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,676,704	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/20/2011 7:59 am
Title XVIII			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT	0	0	0.00	0	0
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,468,657
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,145,361
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					275,151
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					253,655
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					528,806
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					416
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					716.54
89.00 Observation bed cost (line 87 x line 88) (see instructions)					298,081

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 12/20/2011 7:59 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 12/20/2011 7:59 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,170,000		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
32.00	CORONARY CARE UNIT		0		32.00
33.00	BURN INTENSIVE CARE UNIT		0		33.00
34.00	SURGICAL INTENSIVE CARE UNIT		0		34.00
40.00	SUBPROVIDER - I PF		0		40.00
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	0.461225	405,026	186,808	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.093417	18,878	1,764	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.338802	242,911	82,299	54.00
54.01	ULTRASOUND	0.107227	78,428	8,410	54.01
55.00	RADIOLOGY - THERAPEUTIC	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0.372593	82,436	30,715	56.00
57.00	CT SCAN	0.068438	515,392	35,272	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.227209	60,237	13,686	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.269062	939,599	252,810	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.293806	139,984	41,128	65.00
65.01	SLEEP LAB	0.295213	0	0	65.01
66.00	PHYSICAL THERAPY	0.294507	145,065	42,723	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.264568	46,945	12,420	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.332127	163,037	54,149	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.806478	307,181	247,735	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.287978	1,575,800	453,796	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	CARDIAC REHAB	0.957716	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.488198	9,659	4,716	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.327223	170	226	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0.000000	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0.000000	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		4,730,748	1,468,657	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)		4,730,748		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3	
		Component CCN: 14Z349		Date/Time Prepared: 12/20/2011 7:59 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
32.00	CORONARY CARE UNIT		0		32.00
33.00	BURN INTENSIVE CARE UNIT		0		33.00
34.00	SURGICAL INTENSIVE CARE UNIT		0		34.00
40.00	SUBPROVIDER - I PF		0		40.00
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	0.461225	3,754	1,731	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.093417	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.338802	21,023	7,123	54.00
54.01	ULTRASOUND	0.107227	1,281	137	54.01
55.00	RADIOLOGY - THERAPEUTIC	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0.372593	4,054	1,510	56.00
57.00	CT SCAN	0.068438	23,454	1,605	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.227209	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.269062	93,029	25,031	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.293806	30,082	8,838	65.00
65.01	SLEEP LAB	0.295213	0	0	65.01
66.00	PHYSICAL THERAPY	0.294507	185,199	54,542	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.264568	2,363	625	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.332127	10,903	3,621	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.806478	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.287978	315,264	90,789	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	CARDIAC REHAB	0.957716	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.488198	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.327223	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	AMBULANCE SERVICES				95.00
96.00	DURABLE MEDICAL EQUIP. - RENTED	0.000000	0	0	96.00
97.00	DURABLE MEDICAL EQUIP. - SOLD	0.000000	0	0	97.00
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		690,406	195,552	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)		690,406		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/20/2011 7:59 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,015,192 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,015,192 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			4,055,344 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)			42,647 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,106,664 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)			1,906,033 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)			1,906,033 30.00
31.00	Primary payer payments			475 31.00
32.00	Subtotal (line 30 minus line 31)			1,905,558 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)			345,532 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			345,532 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			287,673 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,251,090 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			2,251,090 40.00
41.00	Interim payments			2,328,269 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)			-77,179 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/20/2011 7:59 am
	Title XVIII	Hospital	Cost
	Overrides		
	1.00		
112.00	Override of Ancillary service charges (line 12)		0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 12/20/2011 7:59 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		2,611,447		2,235,249	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/21/2011	24,736	01/21/2011	60,177	3.01	
3.02		05/20/2011	17,332	05/20/2011	32,843	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		42,068		93,020	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,653,515		2,328,269	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		128,625		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		77,179	6.02	
7.00	Total Medicare program liability (see instructions)		2,782,140		2,251,090	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: 141349		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 12/20/2011 7:59 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		795,463		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	01/21/2011	2,032		0		3.01
3.02		05/20/2011	1,120		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,152		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)		798,615		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		82,213		0		6.02
7.00	Total Medicare program liability (see instructions)		716,402		0		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2
		Component CCN: 14Z349		Date/Time Prepared: 12/20/2011 7:59 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)		534,094	0 1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			0 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)		197,508	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		738	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	0 7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		731,602	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		731,602	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)		731,602	0 12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		15,200	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)		716,402	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)		716,402	0 19.00
20.00	Interim payments		798,615	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)		-82,213	0 22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0 23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 12/20/2011 7:59 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			3,145,361 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)			3,145,361 4.00
5.00	Primary payer payments			1,731 5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)			3,175,084 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)			3,175,084 19.00
20.00	Deductibles (exclude professional component)			478,342 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)			2,696,742 22.00
23.00	Coinsurance			3,356 23.00
24.00	Subtotal (line 22 minus line 23)			2,693,386 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			88,754 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			88,754 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			71,548 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))			2,782,140 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,782,140 30.00
31.00	Interim payments			2,653,515 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)			128,625 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 141349 Period: From 07/01/2010 To 06/30/2011 Worksheet G
 Date/Time Prepared: 12/20/2011 7:59 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	8,130,174	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,300,885	0	0	0	4.00
5.00	Other receivable	200,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,500,000	0	0	0	6.00
7.00	Inventory	565,527	0	0	0	7.00
8.00	Prepaid expenses	430,234	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,126,820	0	0	0	11.00
FIXED ASSETS						
12.00	Land	179,834	0	0	0	12.00
13.00	Land improvements	663,393	0	0	0	13.00
14.00	Accumulated depreciation	-551,650	0	0	0	14.00
15.00	Buildings	15,502,648	0	0	0	15.00
16.00	Accumulated depreciation	-8,547,267	0	0	0	16.00
17.00	Leasehold improvements	23,103	0	0	0	17.00
18.00	Accumulated depreciation	-8,149	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,009,588	0	0	0	23.00
24.00	Accumulated depreciation	-7,689,869	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	459,321	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)	10,040,952	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,516,816	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	122,347	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,639,163	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,806,935	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	851,796	0	0	0	37.00
38.00	Salaries, wages, and fees payable	617,008	0	0	0	38.00
39.00	Payroll taxes payable	854,674	0	0	0	39.00
40.00	Notes and loans payable (short term)	358,403	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	34,844	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,716,725	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,728,325	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,728,325	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,445,050	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	17,361,885				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)	17,361,885	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,806,935	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141349

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

Worksheet G-1

Date/Time Prepared:
12/20/2011 7:59 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		14,870,903	
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,490,982			2.00
3.00	Total (sum of line 1 and line 2)		17,361,885		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		17,361,885		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,361,885		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141349

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

Worksheet G-1

Date/Time Prepared:
12/20/2011 7:59 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00			0		0	10.00
11.00			0		0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141349

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

Worksheet G-2 Parts

Date/Time Prepared:
12/20/2011 7:59 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,623,000		1,623,000	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	103,320		103,320	5.00
6.00	Swing bed - NF	8,400		8,400	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,734,720		1,734,720	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,734,720		1,734,720	17.00
18.00	Ancillary services	7,725,005	34,780,631	42,505,636	18.00
19.00	Outpatient services	61,539	4,016,285	4,077,824	19.00
20.00	RURAL HEALTH CLINIC	0	4,447,788	4,447,788	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,134,698	1,134,698	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PHYSICIAN CLINICS	0	1,004,192	1,004,192	27.00
27.01	PROFESSIONAL FEES	0	509,264	509,264	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,521,264	45,892,858	55,414,122	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,021,350		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	INTEREST EXPENSE	175,487			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		175,487		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,845,863		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 12/20/2011 7:59 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	55,414,122	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,544,111	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,870,011	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,845,863	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,024,148	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	78,961	6.00
7.00	Income from investments	88,342	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	30,166	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	49,513	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	35,423	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	19,800	22.00
23.00	Governmental appropriations	246,497	23.00
24.00	THE CENTER INCOME	85,641	24.00
24.01	MISCELLANEOUS INCOME	7,978	24.01
25.00	Total other income (sum of lines 6-24)	642,321	25.00
26.00	Total (line 5 plus line 25)	2,666,469	26.00
27.00	INTEREST EXPENSE	175,487	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	175,487	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,490,982	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS	Provider CCN: 141349	Period: From 07/01/2010	Worksheet H
	HHA CCN: 147694	To 06/30/2011	
		Home Health Agency I	PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	130,334	0	0	0	54,394	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	245,006	0	42,421	0	0	6.00
7.00	Physical Therapy	54,503	0	0	16,141	0	7.00
8.00	Occupational Therapy	0	0	0	27,381	0	8.00
9.00	Speech Pathology	0	0	0	6,013	0	9.00
10.00	Medical Social Services	0	0	0	540	0	10.00
11.00	Home Health Aide	8,993	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	438,836	0	42,421	50,075	54,394	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS		Provider CCN: 141349 HHA CCN: 147694		Period: From 07/01/2010 To 06/30/2011		Worksheet H Date/Time Prepared: 12/20/2011 7:59 am	
				Home Health Agency I		PPS	
		Total (sum of col. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	184,728	-15,959	168,769	0	168,769	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	287,427	0	287,427	0	287,427	6.00
7.00	Physical Therapy	70,644	0	70,644	0	70,644	7.00
8.00	Occupational Therapy	27,381	0	27,381	0	27,381	8.00
9.00	Speech Pathology	6,013	0	6,013	0	6,013	9.00
10.00	Medical Social Services	540	0	540	0	540	10.00
11.00	Home Health Aide	8,993	0	8,993	0	8,993	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	585,726	-15,959	569,767	0	569,767	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST	Provider CCN: 141349	Period: From 07/01/2010	Worksheet H-1 Part I Date/Time Prepared: 12/20/2011 7:59 am
	HHA CCN: 147694	To 06/30/2011	
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0		3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	168,769	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	287,427	0	0	0	6.00
7.00	Physical Therapy	70,644	0	0	0	7.00
8.00	Occupational Therapy	27,381	0	0	0	8.00
9.00	Speech Pathology	6,013	0	0	0	9.00
10.00	Medical Social Services	540	0	0	0	10.00
11.00	Home Health Aide	8,993	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	569,767	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 141349	Period: From 07/01/2010	Worksheet H-1 Part I
		HHA CCN: 147694	To 06/30/2011	Date/Time Prepared: 12/20/2011 7:59 am
			Home Health Agency I	PPS

	Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures	0		1.00
2.00	Capital Related - Movable Equipment	0		2.00
3.00	Plant Operations & Maintenance	0		3.00
4.00	Transportation			4.00
5.00	Administrative and General	168,769	168,769	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	287,427	120,970	408,397
7.00	Physical Therapy	70,644	29,732	100,376
8.00	Occupational Therapy	27,381	11,524	38,905
9.00	Speech Pathology	6,013	2,531	8,544
10.00	Medical Social Services	540	227	767
11.00	Home Health Aide	8,993	3,785	12,778
12.00	Supplies (see instructions)	0	0	0
13.00	Drugs	0	0	0
14.00	DME	0	0	0
HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0	0
16.00	Respiratory Therapy	0	0	0
17.00	Private Duty Nursing	0	0	0
18.00	Clinic	0	0	0
19.00	Health Promotion Activities	0	0	0
20.00	Day Care Program	0	0	0
21.00	Home Delivered Meals Program	0	0	0
22.00	Homemaker Service	0	0	0
23.00	All Others	0	0	0
24.00	Total (sum of lines 1-23)	400,998		569,767

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 141349	Period: From 07/01/2010	Worksheet H-1
	HHA CCN: 147694	To 06/30/2011	Part II Date/Time Prepared: 12/20/2011 7:59 am
		Home Health Agency I	PPS

	Capital Related Costs				Transportation (MILEAGE)	Reconciliation	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)				
	1.00	2.00	3.00	4.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-168,769	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-168,769	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 141349	Period:	Worksheet H-1
	HHA CCN: 147694	From 07/01/2010 To 06/30/2011	Part II Date/Time Prepared: 12/20/2011 7:59 am
		Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	400,998	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	287,427	6.00
7.00	Physical Therapy	70,644	7.00
8.00	Occupational Therapy	27,381	8.00
9.00	Speech Pathology	6,013	9.00
10.00	Medical Social Services	540	10.00
11.00	Home Health Aide	8,993	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others	0	23.00
24.00	Total (sum of lines 1-23)	400,998	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	168,769	25.00
26.00	Unit Cost Multiplier	0.420872	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	Provider CCN: 141349 HHA CCN: 147694	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part I Date/Time Prepared: 12/20/2011 7:59 am PPS
		Home Health Agency I	

	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS		
		BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP			
		1.00	1.01	2.00			
1.00	Administrative and General	0	14,669	0	14,968	24,921	1.00
2.00	Skilled Nursing Care	408,397	0	0	0	51,961	2.00
3.00	Physical Therapy	100,376	0	0	0	11,559	3.00
4.00	Occupational Therapy	38,905	0	0	0	0	4.00
5.00	Speech Pathology	8,544	0	0	0	0	5.00
6.00	Medical Social Services	767	0	0	0	0	6.00
7.00	Home Health Aide	12,778	0	0	0	1,907	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	569,767	14,669	0	14,968	90,348	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 141349 HHA CCN: 147694		Period: From 07/01/2010 To 06/30/2011		Worksheet H-2 Part I Date/Time Prepared: 12/20/2011 7:59 am	
				Home Health Agency I		PPS	
		Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4A	5.00	6.00	7.00	8.00	
1.00	Administrative and General	54,558	13,231	6,441	0	0	1.00
2.00	Skilled Nursing Care	460,358	111,640	0	0	0	2.00
3.00	Physical Therapy	111,935	27,145	0	0	0	3.00
4.00	Occupational Therapy	38,905	9,435	0	0	0	4.00
5.00	Speech Pathology	8,544	2,072	0	0	0	5.00
6.00	Medical Social Services	767	186	0	0	0	6.00
7.00	Home Health Aide	14,685	3,561	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	689,752	167,270	6,441	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000					21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part I Date/Time Prepared: 12/20/2011 7:59 am
		HHA CCN: 147694	Home Health Agency I	PPS

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

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 141349 HHA CCN: 147694		Period: From 07/01/2010 To 06/30/2011		Worksheet H-2 Part I Date/Time Prepared: 12/20/2011 7:59 am PPS	
		Home Health Agency I					
		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		14.00	15.00	16.00	17.00		
1.00	Administrative and General	0	0	0	0	1.00	1.00
2.00	Skilled Nursing Care	0	0	0	0	2.00	2.00
3.00	Physical Therapy	0	0	0	0	3.00	3.00
4.00	Occupational Therapy	0	0	0	0	4.00	4.00
5.00	Speech Pathology	0	0	0	0	5.00	5.00
6.00	Medical Social Services	0	0	0	0	6.00	6.00
7.00	Home Health Aide	0	0	0	0	7.00	7.00
8.00	Supplies (see instructions)	0	0	0	0	8.00	8.00
9.00	Drugs	0	0	0	0	9.00	9.00
10.00	DME	0	0	0	0	10.00	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	11.00	11.00
12.00	Respiratory Therapy	0	0	0	0	12.00	12.00
13.00	Private Duty Nursing	0	0	0	0	13.00	13.00
14.00	Clinic	0	0	0	0	14.00	14.00
15.00	Health Promotion Activities	0	0	0	0	15.00	15.00
16.00	Day Care Program	0	0	0	0	16.00	16.00
17.00	Home Delivered Meals Program	0	0	0	0	17.00	17.00
18.00	Homemaker Service	0	0	0	0	18.00	18.00
19.00	All Others	0	0	0	0	19.00	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	20.00	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	Provider CCN: 141349	Period: From 07/01/2010	Worksheet H-2
	HHA CCN: 147694	To 06/30/2011	Part I Date/Time Prepared: 12/20/2011 7:59 am
		Home Health Agency I	PPS

	OTHER GENERAL SERVICE (SPECIFY)	INTERNS & RESIDENTS					
		NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM. COSTS		
		18.00	19.00	20.00	21.00	22.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 141349 HHA CCN: 147694		Period: From 07/01/2010 To 06/30/2011		Worksheet H-2 Part I Date/Time Prepared: 12/20/2011 7:59 am	
				Home Health Agency I		PPS	
	PARAMED. ED. PRGM.	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)		
	23.00	24.00	25.00	26.00	27.00		
1.00	Administrative and General	0	74,230	0	74,230		1.00
2.00	Skilled Nursing Care	0	571,998	0	571,998	53,798	2.00
3.00	Physical Therapy	0	139,080	0	139,080	13,081	3.00
4.00	Occupational Therapy	0	48,340	0	48,340	4,547	4.00
5.00	Speech Pathology	0	10,616	0	10,616	998	5.00
6.00	Medical Social Services	0	953	0	953	90	6.00
7.00	Home Health Aide	0	18,246	0	18,246	1,716	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	863,463	0	863,463	74,230	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.094053	21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part I Date/Time Prepared: 12/20/2011 7:59 am
		HHA CCN: 147694	Home Health Agency I	PPS

		Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	625,796	2.00
3.00	Physical Therapy	152,161	3.00
4.00	Occupational Therapy	52,887	4.00
5.00	Speech Pathology	11,614	5.00
6.00	Medical Social Services	1,043	6.00
7.00	Home Health Aide	19,962	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others	0	19.00
20.00	Total (sum of lines 1-19) (2)	863,463	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part II
	HHA CCN: 147694		Date/Time Prepared: 12/20/2011 7:59 am
		Home Health Agency I	PPS

	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
	BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	1.01	2.00	4.00			
1.00	Administrative and General	1,434	0	14,609	117,505	0	1.00
2.00	Skilled Nursing Care	0	0	0	245,006	0	2.00
3.00	Physical Therapy	0	0	0	54,503	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	8,993	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,434	0	14,609	426,007		20.00
21.00	Total cost to be allocated	14,669	0	14,968	90,348		21.00
22.00	Unit cost multiplier	10.229428	0.000000	1.024574	0.212081		22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141349 HHA CCN: 147694	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part II Date/Time Prepared: 12/20/2011 7:59 am PPS
		Home Health Agency I	

	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
	5.00	6.00	7.00	8.00	9.00	
1.00 Administrative and General	54,558	1,434	0	0	0	1.00
2.00 Skilled Nursing Care	460,358	0	0	0	0	2.00
3.00 Physical Therapy	111,935	0	0	0	0	3.00
4.00 Occupational Therapy	38,905	0	0	0	0	4.00
5.00 Speech Pathology	8,544	0	0	0	0	5.00
6.00 Medical Social Services	767	0	0	0	0	6.00
7.00 Home Health Aide	14,685	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	689,752	1,434	0	0	0	20.00
21.00 Total cost to be allocated	167,270	6,441	0	0	0	21.00
22.00 Unit cost multiplier	0.242507	4.491632	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141349	Period: From 07/01/2010	Worksheet H-2 Part II Date/Time Prepared: 12/20/2011 7:59 am
	HHA CCN: 147694	To 06/30/2011	
		Home Health Agency I	PPS

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141349	Period: From 07/01/2010	Worksheet H-2 Part II Date/Time Prepared: 12/20/2011 7:59 am
	HHA CCN: 147694	To 06/30/2011	
		Home Health Agency I	PPS

	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
				15.00			16.00
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 141349	Period: From 07/01/2010	Worksheet H-2 Part II Date/Time Prepared: 12/20/2011 7:59 am
	HHA CCN: 147694	To 06/30/2011	
		Home Health Agency I	PPS

	NURSING SCHOOL	INTERNS & RESIDENTS			PARAMED. ED. PRGM. (ASSIGNED TIME)	
		(ASSIGNED TIME)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			20.00	21.00		
1.00	Administrative and General	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	9.00
10.00	DME	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	18.00
19.00	All Others	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 141349 HHA CCN: 147694	Period: From 07/01/2010 To 06/30/2011	Worksheet H-3 Parts I-II Date/Time Prepared: 12/20/2011 7:59 am	
				Title XVIII	Home Health Agency I	PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	625,796		625,796	3,699	1.00
2.00	Physical Therapy	3.00	152,161	0	152,161	1,826	2.00
3.00	Occupational Therapy	4.00	52,887	0	52,887	324	3.00
4.00	Speech Pathology	5.00	11,614	0	11,614	58	4.00
5.00	Medical Social Services	6.00	1,043		1,043	7	5.00
6.00	Home Health Aide	7.00	19,962		19,962	73	6.00
7.00	Total (sum of lines 1-6)		863,463	0	863,463	5,987	7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits		
		0	1.00	2.00	Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	0		8.00
8.01	Skilled Nursing Care		41180	0	0		8.01
9.00	Physical Therapy		99914	0	0		9.00
9.01	Physical Therapy		41180	0	0		9.01
10.00	Occupational Therapy		99914	0	0		10.00
10.01	Occupational Therapy		41180	0	0		10.01
11.00	Speech Pathology		99914	0	0		11.00
11.01	Speech Pathology		41180	0	0		11.01
12.00	Medical Social Services		99914	0	0		12.00
12.01	Medical Social Services		41180	0	0		12.01
13.00	Home Health Aide		99914	0	0		13.00
13.01	Home Health Aide		41180	0	0		13.01
14.00	Total (sum of lines 8-13)			0	0		14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	6,329	6,329	19,055	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
Cost Center Description		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)		
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.294507	0	0	1.00
2.00	Occupational Therapy		67.00	0.000000	0	0	2.00
3.00	Speech Pathology		68.00	0.000000	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.332127	19,055	6,329	4.00
5.00	Cost of Drugs		73.00	0.287978	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 141349 HHA CCN: 147694	Period: From 07/01/2010 To 06/30/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 12/20/2011 7:59 am	
		Title XVIII	Home Health Agency I	PPS	
Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		5.00	6.00	7.00	8.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00	Skilled Nursing Care	169.18	1,589	1,205	1.00
2.00	Physical Therapy	83.33	978	483	2.00
3.00	Occupational Therapy	163.23	128	143	3.00
4.00	Speech Pathology	200.24	17	57	4.00
5.00	Medical Social Services	149.00	2	1	5.00
6.00	Home Health Aide	273.45	41	29	6.00
7.00	Total (sum of lines 1-6)		2,755	1,918	7.00
Cost Center Description		5.00	6.00	7.00	8.00
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
8.01	Skilled Nursing Care				8.01
9.00	Physical Therapy				9.00
9.01	Physical Therapy				9.01
10.00	Occupational Therapy				10.00
10.01	Occupational Therapy				10.01
11.00	Speech Pathology				11.00
11.01	Speech Pathology				11.01
12.00	Medical Social Services				12.00
12.01	Medical Social Services				12.01
13.00	Home Health Aide				13.00
13.01	Home Health Aide				13.01
14.00	Total (sum of lines 8-13)				14.00
Cost Center Description		Ratio (col. 3 ÷ col. 4)	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		5.00	6.00	7.00	8.00
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0.332144	5,243	13,812	0
16.00	Cost of Drugs	0.000000	0	0	0
Cost Center Description		Transfer to Part I as Indicated			
		4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00	Physical Therapy	col. 2, line 2.00			1.00
2.00	Occupational Therapy	col. 2, line 3.00			2.00
3.00	Speech Pathology	col. 2, line 4.00			3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00			4.00
5.00	Cost of Drugs	col. 2, line 16.00			5.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 141349	Period:	Worksheet H-3
	HHA CCN: 147694	From 07/01/2010 To 06/30/2011	Parts I-III Date/Time Prepared: 12/20/2011 7:59 am
	Title XVIII	Home Health Agency I	PPS

Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)		
	Part A	Part B				
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance			
	9.00	10.00	11.00	12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	268,827	203,862		472,689	1.00
2.00	Physical Therapy	81,497	40,248		121,745	2.00
3.00	Occupational Therapy	20,893	23,342		44,235	3.00
4.00	Speech Pathology	3,404	11,414		14,818	4.00
5.00	Medical Social Services	298	149		447	5.00
6.00	Home Health Aide	11,211	7,930		19,141	6.00
7.00	Total (sum of lines 1-6)	386,130	286,945		673,075	7.00
Cost Center Description						
		10.00	11.00	12.00		
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
8.01	Skilled Nursing Care					8.01
9.00	Physical Therapy					9.00
9.01	Physical Therapy					9.01
10.00	Occupational Therapy					10.00
10.01	Occupational Therapy					10.01
11.00	Speech Pathology					11.00
11.01	Speech Pathology					11.01
12.00	Medical Social Services					12.00
12.01	Medical Social Services					12.01
13.00	Home Health Aide					13.00
13.01	Home Health Aide					13.01
14.00	Total (sum of lines 8-13)					14.00
Cost of Services						
Cost Center Description	Part A	Part B				
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance			
	9.00	10.00	11.00			
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	1,741	4,588	0		15.00
16.00	Cost of Drugs	0	0	0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 141349 HHA CCN: 147694	Period: From 07/01/2010 To 06/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 12/20/2011 7:59 am
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		419,998	263,593
12.00	Total PPS Reimbursement - Full Episodes with Outliers		3,349	10,728
13.00	Total PPS Reimbursement - LUPA Episodes		5,652	3,180
14.00	Total PPS Reimbursement - PEP Episodes		7,292	5,208
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		436,291	282,709
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		436,291	282,709
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		436,291	282,709
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		436,291	282,709
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		436,291	282,709
32.00	Interim payments (see instructions)		436,291	282,709
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141349	Period: From 07/01/2010	Worksheet H-5
	HHA CCN: 147694	To 06/30/2011	Date/Time Prepared: 12/20/2011 7:59 am
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		436,291		282,709	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		436,291		282,709	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		436,291		282,709	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS		Provider CCN: 141349 Component CCN: 143464		Period: From 07/01/2010 To 06/30/2011		Worksheet M-1 Date/Time Prepared: 12/20/2011 7:59 am	
		Title XVIII		Rural Health Clinic (RHC) I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
						Reclassified Trial Balance (col. 3 + col. 4)	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,403,986	0	1,403,986	0	1,403,986	1.00
2.00	Physician Assistant	240,692	0	240,692	0	240,692	2.00
3.00	Nurse Practitioner	318,685	0	318,685	0	318,685	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	701,322	0	701,322	0	701,322	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	2,664,685	0	2,664,685	0	2,664,685	10.00
11.00	Physician Services Under Agreement	0	162,715	162,715	0	162,715	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	162,715	162,715	0	162,715	14.00
15.00	Medical Supplies	0	30,199	30,199	0	30,199	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	152,020	152,020	0	152,020	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	182,219	182,219	0	182,219	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,664,685	344,934	3,009,619	0	3,009,619	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	199,944	199,944	0	199,944	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	199,944	199,944	0	199,944	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	159,792	817,043	976,835	-525,654	451,181	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	159,792	817,043	976,835	-525,654	451,181	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,824,477	1,361,921	4,186,398	-525,654	3,660,744	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet M-1
	Component CCN: 143464		Date/Time Prepared: 12/20/2011 7:59 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	-145,426	1,258,560	1.00
2.00	Physician Assistant	0	240,692	2.00
3.00	Nurse Practitioner	0	318,685	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	701,322	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	-145,426	2,519,259	10.00
11.00	Physician Services Under Agreement	0	162,715	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	162,715	14.00
15.00	Medical Supplies	0	30,199	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	152,020	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	182,219	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-145,426	2,864,193	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	199,944	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	199,944	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	451,181	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	451,181	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-145,426	3,515,318	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES			Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet M-2	
			Component CCN: 143464		Date/Time Prepared: 12/20/2011 7:59 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	5.45	20,488	4,200	22,890	1.00
2.00	Physician Assistant	1.75	7,068	2,100	3,675	2.00
3.00	Nurse Practitioner	3.20	11,507	2,100	6,720	3.00
4.00	Subtotal (sum of lines 1-3)	10.40	39,063		33,285	39,063
5.00	Visiting Nurse	0.00	0		0	0
6.00	Clinical Psychologist	0.00	0		0	0
7.00	Clinical Social Worker	0.00	0		0	0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	0
8.00	Total FTEs and Visits (sum of lines 4-7)	10.40	39,063			39,063
9.00	Physician Services Under Agreements		0			0
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				2,864,193	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				199,944	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				3,064,137	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				0.934747	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				451,181	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				2,055,634	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,506,815	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				2,506,815	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				2,343,238	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				5,207,431	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141349	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3	
		Component CCN: 143464		Date/Time Prepared: 12/20/2011 7:59 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)			5,207,431	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)			72,213	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,135,218	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)			39,063	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)			39,063	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			131.46	7.00
			Calculation of Limit (1)		
			Prior to January 1	On or After January 1	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)		77.76	78.07	8.00
9.00	Rate for Program covered visits (see instructions)		131.46	131.46	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		5,242	5,243	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		689,113	689,245	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) *		689,113	689,245	16.00
16.01	Total program charges (see instructions)(from contractor's records)			487,507	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			12,244	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			17,311	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)			431,016	16.04
16.05	Total program cost (see instructions)		551,290	448,327	16.05
17.00	Primary payer amounts			216	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			133,164	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			166,524	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			999,401	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			27,503	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,026,904	22.00
23.00	Reimbursable bad debts (see instructions)			12,209	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			12,209	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)			1,039,113	26.00
27.00	Interim payments			946,359	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)			92,754	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter I, section 115.2			0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141349 Component CCN: 143464	Period: From 07/01/2010 To 06/30/2011	Worksheet M-4 Date/Time Prepared: 12/20/2011 7:59 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	2,519,259	2,519,259	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000508	0.002271	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,280	5,721	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	12,321	19,187	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	13,601	24,908	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	2,864,193	2,864,193	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	2,506,815	2,506,815	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004749	0.008696	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	11,905	21,799	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	25,506	46,707	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	343	1,533	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	74.36	30.47	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	115	622	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	8,551	18,952	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		72,213	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		27,503	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141349 Component CCN: 143464	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 12/20/2011 7:59 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		996,413	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50		01/21/2011	50,054	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)		-50,054	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		946,359	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		92,754	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,039,113	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00