

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/14/2012 4:16 pm
--------------------------------------------------------------------------------------------	----------------------	---------------------------------------	----------------------------------------------------------------

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/14/2012 Time: 4:16 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SARAH BUSH LINCOLN HEALTH CENTER for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 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

	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	330,767	-406,778	0	0	1.00
2.00 Subprovider - IPF	0	75,790	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00 RURAL HEALTH CLINIC I	0		1,626		0	10.00
10.01 RURAL HEALTH CLINIC II II	0		872		0	10.01
10.02 RURAL HEALTH CLINIC III III	0		989		0	10.02
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	406,557	-403,290	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.

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/14/2012 4:16 pm
--------------------------------------------------------------------------------------------	----------------------	---------------------------------------	----------------------------------------------------------------

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/14/2012 Time: 4:16 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SARAH BUSH LINCOLN HEALTH CENTER for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 11/14/2012 Time: 4:16 pm
U4fH8GFxw3w59M7r1YxwBKslbbU5.0
pH9hV0pkqnHCDg09zkWKJeQV8N41U1
6r561FyrmSOCgUzX
PI: Date: 11/14/2012 Time: 4:16 pm
X1KgQmdnEN2BiHup099Pc85qnp7.01
62QTiOhSIe6c2t77.bAJGR9wuwH30H
jErsfEjLGI.0.ZXdd

(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	330,767	-406,778	0	0	1.00
2.00 Subprovider - IPF	0	75,790	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00 RURAL HEALTH CLINIC I	0		1,626		0	10.00
10.01 RURAL HEALTH CLINIC II II	0		872		0	10.01
10.02 RURAL HEALTH CLINIC III IIII	0		989		0	10.02
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	406,557	-403,290	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: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/14/2012 4:15 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1000 HEALTH CENTER DRIVE			PO Box: 372						1.00	
2.00	City: MATTOON			State: IL		Zip Code: 61920-		County: COLES		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SARAH BUSH LINCOLN HEALTH CENTER	140189	99914	1	05/01/1977	N	P	O	3.00
4.00	Subprovider - IPF		SARAH BUSH LINCOLN HEALTH CENTER	14S189	99914	4	01/01/1990	N	P	O	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF						N	N	N		7.00
8.00	Swing Beds - NF						N		N		8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		LINCOLN LAND HOME CARE OF SBLHS	147594	99914		06/18/1996	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		LINCOLN LAND HOSPICE OF SBLHS	141599	99914		08/10/1999				14.00
15.00	Hospital-Based Health Clinic - RHC		CASEY RHC	143978	99914		06/15/1992	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1		SULLIVAN RHC	143998	99914		01/13/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC 2		NEOGA RHC	143435	99914		05/31/1997	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) 1										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2011		06/30/2012		20.00	
21.00	Type of Control (see instructions)							2		21.00	
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					1		N		23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid 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 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 paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		3,209	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the 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 paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0		25.00	
						Urban/Rural	S	Date of Geogr			
						1.00		2.00			
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	For the Standard Geographic Classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							2		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							1		35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/14/2012 4:15 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	07/01/2011	06/30/2012		36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
11/14/2012 4:15 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/14/2012 4:15 pm		
		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.	Y				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
		1.00				
Long Term Care Hospital PPS						
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)		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.	Y		N		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00		2.00		3.00
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. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/14/2012 4:15 pm	
		1.00	2.00	3.00	
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
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	6,833,402	0	0	118.01
		1.00	2.00		
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	Y	Y		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:		141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:	Zip Code:		143.00
		1.00	2.00		
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, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N			145.00
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/14/2012 4:15 pm	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
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	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC	N	N	N	N	161.00	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/14/2012 4:15 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Type	Date
			1.00	2.00	3.00
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N	Legal Oper.	
			1.00	2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			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	09/30/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/14/2012 4:15 pm
		Part A		
Description		Y/N	Date	
0		1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			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.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			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.			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			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			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.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	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
				1.00
				2.00
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BARB	IPPOLITO	41.00
42.00	Enter the employer/company name of the cost report preparer.	SARAH BUSH LINCOLN HEALTH CENTER		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-258-2509	BI PPOLITO@SBLHS.ORG	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/30/2012	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
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMB. ACCOUNTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	81	29,646	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		81	29,646	0.00		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT	32.00	8	2,928	0.00		9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		89	32,574	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,320			16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.01 RURAL HEALTH CLINIC II	88.01					26.01
26.02 RURAL HEALTH CLINIC III	88.02					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		109				27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF	40.00					28.01
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	11,200	2,502	18,335		1.00
2.00 HMO		731	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	11,200	2,502	18,335		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT	0	1,017	185	1,658		9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		705	1,210		13.00
14.00 Total (see instructions)	0	12,217	3,392	21,203		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	1,379	1,109	3,846		16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	22,183	0	30,483		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	796	0	3,861		26.00
26.01 RURAL HEALTH CLINIC II	0	564	0	3,135		26.01
26.02 RURAL HEALTH CLINIC III	0	1,136	0	5,892		26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	3,492		28.00
28.01 SUBPROVIDER - IPF				0		28.01
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			304	550		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	2,961	1.00
2.00 HMO					192	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	1,304.69	0.00	0	2,961	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	22.92	0.00	0	249	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	51.05	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	23.62	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	5.65	0.00			26.00
26.01 RURAL HEALTH CLINIC II	0.00	6.24	0.00			26.01
26.02 RURAL HEALTH CLINIC III	0.00	7.22	0.00			26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	1,421.39	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,151	6,038		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	1,151	6,038		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	299	936		16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.01 RURAL HEALTH CLINIC II				26.01
26.02 RURAL HEALTH CLINIC III				26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.01 SUBPROVIDER - IPF				28.01
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
PART II - WAGE DATA						
SALARIES						
1.00	Total salaries (see instructions)	200.00	92,151,031	0	92,151,031	2,956,131.00 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00 2.00
3.00	Non-physician anesthetist Part B		1,754,161	0	1,754,161	19,121.00 3.00
4.00	Physician-Part A - Administrative		680,203	0	680,203	2,922.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00 4.01
5.00	Physician-Part B		8,592,871	0	8,592,871	45,844.00 5.00
6.00	Non-physician-Part B		499,325	0	499,325	6,393.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00 7.01
8.00	Home office personnel		0	0	0	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00 9.00
10.00	Excluded area salaries (see instructions)		31,915,852	0	31,915,852	731,584.00 10.00
OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		27,857	0	27,857	155.00 11.00
12.00	Contract management and administrative services		0	0	0	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00 13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00 14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00 15.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		23,347,366	0	23,347,366	17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	18.00
19.00	Excluded areas		5,122,718	0	5,122,718	19.00
20.00	Non-physician anesthetist Part A		0	0	0	20.00
21.00	Non-physician anesthetist Part B		413,443	0	413,443	21.00
22.00	Physician Part A - Administrative		89,115	0	89,115	22.00
22.01	Physician Part A - Teaching		0	0	0	22.01
23.00	Physician Part B		1,201,650	0	1,201,650	23.00
24.00	Wage-related costs (RHC/FQHC)		83,494	0	83,494	24.00
25.00	Interns & residents (in an approved program)		0	0	0	25.00
OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	553,093	12,497	565,590	18,331.00 26.00
27.00	Administrative & General	5.00	11,141,277	0	11,141,277	392,962.00 27.00
28.00	Administrative & General under contract (see inst.)		287,824	0	287,824	1,581.50 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00 29.00
30.00	Operation of Plant	7.00	967,071	0	967,071	47,690.00 30.00
31.00	Laundry & Linen Service	8.00	27,630	0	27,630	2,126.00 31.00
32.00	Housekeeping	9.00	1,168,937	0	1,168,937	92,773.00 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00 33.00
34.00	Dietary	10.00	1,236,622	-691,024	545,598	39,256.00 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00 35.00
36.00	Cafeteria	11.00	0	691,024	691,024	49,719.00 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00 37.00
38.00	Nursing Administration	13.00	1,207,137	0	1,207,137	41,158.00 38.00
39.00	Central Services and Supply	14.00	376,279	0	376,279	24,429.00 39.00
40.00	Pharmacy	15.00	1,149,832	0	1,149,832	35,365.00 40.00
41.00	Medical Records & Medical Records Library	16.00	1,488,618	0	1,488,618	83,467.00 41.00
42.00	Social Service	17.00	0	0	0	0.00 42.00
43.00	Other General Service	18.00	0	0	0	0.00 43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART II - WAGE DATA			
SALARIES			
1.00	Total salaries (see instructions)	31.17	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	91.74	3.00
4.00	Physician-Part A - Administrative	232.79	4.00
4.01	Physicians - Part A - Teaching	0.00	4.01
5.00	Physician-Part B	187.44	5.00
6.00	Non-physician-Part B	78.10	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	43.63	10.00
OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	179.72	11.00
12.00	Contract management and administrative services	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative	0.00	13.00
14.00	Home office salaries & wage-related costs	0.00	14.00
15.00	Home office: Physician Part A - Administrative	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative	0.00	16.00
WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A - Administrative		22.00
22.01	Physician Part A - Teaching		22.01
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FQHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	30.85	26.00
27.00	Administrative & General	28.35	27.00
28.00	Administrative & General under contract (see inst.)	181.99	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	20.28	30.00
31.00	Laundry & Linen Service	13.00	31.00
32.00	Housekeeping	12.60	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	13.90	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	13.90	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	29.33	38.00
39.00	Central Services and Supply	15.40	39.00
40.00	Pharmacy	32.51	40.00
41.00	Medical Records & Medical Records Library	17.83	41.00
42.00	Social Service	0.00	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part III
Date/Time Prepared:
11/14/2012 4:15 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)	81,592,498	0	81,592,498	2,886,354.50	1.00
2.00	Excluded area salaries (see instructions)	31,915,852	0	31,915,852	731,584.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	49,676,646	0	49,676,646	2,154,770.50	3.00
4.00	Subtotal other wages & related costs (see inst.)	27,857	0	27,857	155.00	4.00
5.00	Subtotal wage-related costs (see inst.)	23,436,481	0	23,436,481	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	73,140,984	0	73,140,984	2,154,925.50	6.00
7.00	Total overhead cost (see instructions)	19,604,320	12,497	19,616,817	828,857.50	7.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S-3 Part III Date/Time Prepared: 11/14/2012 4:15 pm
---------------------------------	--	----------------------	---------------------------------------------	------------------------------------------------------------------------

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	28.27	1.00
2.00	Excluded area salaries (see instructions)	43.63	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23.05	3.00
4.00	Subtotal other wages & related costs (see inst.)	179.72	4.00
5.00	Subtotal wage-related costs (see inst.)	47.18	5.00
6.00	Total (sum of lines 3 thru 5)	33.94	6.00
7.00	Total overhead cost (see instructions)	23.67	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 11/14/2012 4:15 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			3,877,664 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			555,450 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			11,043,623 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			563,385 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			261,001 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			22,552 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			172,305 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,394,814 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			5,237,423 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			144,724 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			74,425 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			23,347,366 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part V
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00		0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet S-4	
		Component CCN: 147594				Date/Time Prepared: 11/14/2012 4:15 pm	
				Home Health Agency I		PPS	
						1.00	
0.00	County			COLES		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	1,010.00	130.00	326.00	0.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
				0	1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.64	0.00	0.64	
4.00	Director(s) and Assistant Director(s)			1.87	0.00	1.87	
5.00	Other Administrative Personnel			11.37	0.00	11.37	
6.00	Direct Nursing Service			24.59	0.00	24.59	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			5.68	0.00	5.68	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			1.55	0.00	1.55	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.91	0.00	0.91	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.86	0.00	0.86	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			3.58	0.00	3.58	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			
		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	11,879	435	311	217	12,842	
22.00	Skilled Nursing Visit Charges	2,109,617	75,183	59,811	39,129	2,283,740	
23.00	Physical Therapy Visits	4,007	31	55	108	4,201	
24.00	Physical Therapy Visit Charges	741,474	5,642	10,559	20,083	777,758	
25.00	Occupational Therapy Visits	1,279	18	11	38	1,346	
26.00	Occupational Therapy Visit Charges	236,369	3,276	2,002	7,099	248,746	
27.00	Speech Pathology Visits	378	27	4	5	414	
28.00	Speech Pathology Visit Charges	69,587	4,914	728	910	76,139	
29.00	Medical Social Service Visits	229	7	1	5	242	
30.00	Medical Social Service Visit Charges	51,067	1,561	223	1,115	53,966	
31.00	Home Health Aide Visits	2,998	67	13	60	3,138	
32.00	Home Health Aide Visit Charges	233,844	5,226	1,014	4,680	244,764	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	20,770	585	395	433	22,183	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,441,958	95,802	74,337	73,016	3,685,113	
36.00	Total Number of Episodes (standard/non outlier)	1,281		138	32	1,451	
37.00	Total Number of Outlier Episodes		13		0	13	
38.00	Total Non-Routine Medical Supply Charges	114,554	5,401	6,699	1,423	128,077	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978		Period: From 07/01/2011 To 06/30/2012		Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm	
				Rural Health Clinic (RHC) I		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		412 NW 3RD				1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		CASEY		IL		62420 2.00	
3.00							
FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
0 3.00							
Grant Award Date							
1.00 2.00							
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
10.00							
Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)							
		N				0 10.00	
Sunday Monday							
		from to		from to			
		1.00 2.00		3.00 4.00			
11.00 Facility hours of operations (1)							
11.00 Clinic		08:00		17:00		11.00	
12.00							
Have you received an approval for an exception to the productivity standard?							
13.00		N				0 12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.							
Provider name CCN number							
1.00 2.00							
14.00 Provider name, CCN number							
		Y/N		V		XVIII XIX Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00		0		0		0 15.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "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, and the total number of visits in column 5. (see instructions)							

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm Cost
		Rural Health Clinic (RHC) I		
		County		
		4.00		
2.00	City, State, Zip Code, County	CLARK		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm		
			Rural Health Clinic (RHC) I	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm
			Rural Health Clinic (RHC) I	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998		Period: From 07/01/2011 To 06/30/2012		Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm	
				Rural Health Clinic (RHC) II		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		7 HAWTHORNE LANE				1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		SULLIVAN		IL		61951	
2.00							
3.00							
FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
0							
3.00							
Grant Award							
Date							
1.00							
2.00							
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
1.00							
2.00							
10.00 Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N				0	
10.00							
		Sunday		Monday			
		from to		from to			
		1.00 2.00		3.00 4.00			
Facility hours of operations (1)							
11.00 Clinic				08:00		17:00	
11.00							
1.00							
2.00							
12.00 Have you received an approval for an exception to the productivity standard?				N			
13.00 Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.						0	
12.00							
13.00							
Provider name							
CCN number							
1.00							
2.00							
14.00 Provider name, CCN number							
		Y/N		V		Total Visits	
		1.00		2.00		3.00	
				XVIII		XIX	
				3.00		4.00	
						5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "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, and the total number of visits in column 5. (see instructions)				0		0	
						0	
15.00							

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm
			Rural Health Clinic (RHC) II	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	MOULTRIE		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998		Period: From 07/01/2011 To 06/30/2012		Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm	
				Rural Health Clinic (RHC) II		Cost	
		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm
			Rural Health Clinic (RHC) II	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435		Period: From 07/01/2011 To 06/30/2012		Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm		
				Rural Health Clinic (RHC) III		Cost		
						1.00		
1.00	Clinic Address and Identification Street			650 OAK AVENUE		1.00		
		City		State		Zip Code		
		1.00		2.00		3.00		
2.00	City, State, Zip Code, County		NEOGA		IL62447		2.00	
						1.00		
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00		
				Grant Award		Date		
				1.00		2.00		
		Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00		
7.00	Appalachian Regional Commission			0		7.00		
8.00	Look-Alikes			0		8.00		
9.00	OTHER (SPECIFY)			0		9.00		
				1.00		2.00		
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00		
		Sunday		Monday				
		from to		from to				
		1.00 2.00		3.00 4.00				
11.00	Facility hours of operations (1) Clinic			08:00 17:00		11.00		
						1.00 2.00		
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00		
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			0		13.00		
				Provider name		CCN number		
				1.00		2.00		
14.00	Provider name, CCN number					14.00		
		Y/N		V		Total Visits		
		1.00		2.00		3.00 4.00 5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "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, and the total number of visits in column 5. (see instructions)			0 0 0		0 15.00		

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm
			Rural Health Clinic (RHC) III	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	CUMBERLAND		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm		
			Rural Health Clinic (RHC) III	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/14/2012 4:15 pm
			Rural Health Clinic (RHC) III	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 140189
Component CCN: 141599

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-9
Parts I & II
Date/Time Prepared:
11/14/2012 4:15 pm

		Unduplicated Days				All Other	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility		
		1.00	2.00	3.00	4.00		
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	18,666	827	9,304	162	1,593	2.00
3.00	Inpatient Respite Care	60	0	0	0	0	3.00
4.00	General Inpatient Care	34	0	0	0	0	4.00
5.00	Total Hospice Days	18,760	827	9,304	162	1,593	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	19	24	537	9	2	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	987.37	34.46	17.33	18.00	796.50	8.00
9.00	Unduplicated Census Count	0	0	0	0	0	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 140189 Component CCN: 141599	Period: From 07/01/2011 To 06/30/2012	Worksheet S-9 Parts I & II Date/Time Prepared: 11/14/2012 4:15 pm
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	21,086	2.00
3.00	Inpatient Respite Care	60	3.00
4.00	General Inpatient Care	34	4.00
5.00	Total Hospice Days	21,180	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	45	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	470.67	8.00
9.00	Unduplicated Census Count	0	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet S-10 Date/Time Prepared: 11/14/2012 4:15 pm
-----------------------------------------------	----------------------	---------------------------------------------	-------------------------------------------------------------

				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)		0.294738		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		10,719,794		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		6,530,331		5.00
6.00	Medicaid charges		69,746,236		6.00
7.00	Medicaid cost (line 1 times line 6)		20,556,866		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		3,306,741		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		3,306,741		19.00
				1.00	
				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	Uninsured patients	Insured patients	Total (col. 1 + col. 2)	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	7,320,820	16,999,397	24,320,217	21.00
22.00	Partial payment by patients approved for charity care	2,157,724	5,010,368	7,168,092	22.00
23.00	Cost of charity care (line 21 minus line 22)	61,747	1,350,628	1,412,375	23.00
				2,095,977	3,659,740
				5,755,717	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)		4,272,895		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,024,867		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		3,248,028		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		957,317		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		6,713,034		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,019,775		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet A	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	3,782,008	3,782,008	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	7,614,193	7,614,193	2.00
4.00	00400	EMPLOYEE BENEFITS	553,093	18,278,850	18,831,943	18,981,642	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,141,277	28,303,129	39,444,406	27,028,042	5.00
7.00	00700	OPERATION OF PLANT	967,071	3,010,970	3,978,041	3,937,356	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,630	431,964	459,594	459,594	8.00
9.00	00900	HOUSEKEEPING	1,168,937	360,517	1,529,454	1,529,394	9.00
10.00	01000	DIETARY	1,236,622	1,051,266	2,287,888	1,007,954	10.00
11.00	01100	CAFETERIA	0	0	0	1,278,471	11.00
13.00	01300	NURSING ADMINISTRATION	1,207,137	150,687	1,357,824	1,354,262	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	376,279	565,833	942,112	920,693	14.00
15.00	01500	PHARMACY	1,149,832	7,377,575	8,527,407	1,373,768	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,488,618	597,125	2,085,743	2,078,950	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,117,285	1,192,547	10,309,832	9,412,057	30.00
32.00	03200	CORONARY CARE UNIT	1,124,462	161,770	1,286,232	1,285,850	32.00
40.00	04000	SUBPROVIDER - I/PF	2,215,207	226,322	2,441,529	2,451,806	40.00
43.00	04300	NURSERY	0	10,196	10,196	370,677	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,908,817	726,233	3,635,050	3,632,623	50.00
51.00	05100	RECOVERY ROOM	655,971	120,606	776,577	772,014	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	70,383	70,383	617,435	52.00
53.00	05300	ANESTHESIOLOGY	4,666,305	570,247	5,236,552	5,643,212	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,794,801	862,508	2,657,309	2,394,494	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,737,685	412,144	2,149,829	2,182,003	55.00
56.00	05600	RADIOISOTOPE	765,428	1,002,887	1,768,315	1,913,583	56.00
57.00	05700	CT SCAN	317,407	636,226	953,633	1,017,439	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	252,983	259,718	512,701	558,235	58.00
59.00	05900	CARDIAC CATHETERIZATION	380,228	137,841	518,069	516,952	59.00
60.00	06000	LABORATORY	4,169,575	5,005,607	9,175,182	9,180,346	60.00
65.00	06500	RESPIRATORY THERAPY	742,549	231,997	974,546	970,717	65.00
66.00	06600	PHYSICAL THERAPY	1,392,898	269,378	1,662,276	1,648,511	66.00
67.00	06700	OCCUPATIONAL THERAPY	384,853	40,131	424,984	424,984	67.00
68.00	06800	SPEECH PATHOLOGY	649,810	112,978	762,788	761,836	68.00
69.00	06900	ELECTROCARDIOLOGY	1,524,856	796,971	2,321,827	2,349,898	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	330,929	659,813	990,742	985,908	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,232,960	3,232,960	3,232,960	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	3,400,526	3,400,526	3,400,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,011,851	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,373,589	923,619	2,297,208	2,290,012	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	424,510	39,302	463,812	450,362	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	293,545	98,739	392,284	407,958	88.00
88.01	08801	RURAL HEALTH CLINIC II	461,155	115,538	576,693	596,916	88.01
88.02	08802	RURAL HEALTH CLINIC III	658,550	111,592	770,142	797,856	88.02
91.00	09100	EMERGENCY	6,203,742	1,166,045	7,369,787	7,585,596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	2,740,015	709,296	3,449,311	3,435,856	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	1,167,649	905,012	2,072,661	1,876,814	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,771,300	84,337,048	152,108,348	151,523,614	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,840,767	5,095,094	27,935,861	28,664,926	192.00
194.00	07950	WELLNESS	96,474	94,579	191,053	191,053	194.00
194.02	07951	LIFELINE	31,982	125,782	157,764	157,764	194.02
194.03	07952	OCCUPATIONAL HEALTH	583,316	153,880	737,196	593,850	194.03
194.05	07954	MISC. NONREIMBURSABLE	827,192	582,961	1,410,153	1,409,168	194.05
200.00		TOTAL (SUM OF LINES 118-199)	92,151,031	90,389,344	182,540,375	182,540,375	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,010,815	2,771,193	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	7,614,193	2.00
4.00	00400	EMPLOYEE BENEFITS	-321,096	18,660,546	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-246,619	26,781,423	5.00
7.00	00700	OPERATION OF PLANT	-1,792	3,935,564	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	459,594	8.00
9.00	00900	HOUSEKEEPING	-2,637	1,526,757	9.00
10.00	01000	DIETARY	-9,671	998,283	10.00
11.00	01100	CAFETERIA	-701,733	576,738	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,354,262	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	920,693	14.00
15.00	01500	PHARMACY	0	1,373,768	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-93,758	1,985,192	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,090,168	8,321,889	30.00
32.00	03200	CORONARY CARE UNIT	0	1,285,850	32.00
40.00	04000	SUBPROVIDER - IPF	-1,175,555	1,276,251	40.00
43.00	04300	NURSERY	0	370,677	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,632,623	50.00
51.00	05100	RECOVERY ROOM	0	772,014	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	617,435	52.00
53.00	05300	ANESTHESIOLOGY	-5,030,094	613,118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-824	2,393,670	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,145,467	1,036,536	55.00
56.00	05600	RADIOISOTOPE	-4,675	1,908,908	56.00
57.00	05700	CT SCAN	0	1,017,439	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	558,235	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	516,952	59.00
60.00	06000	LABORATORY	-692,652	8,487,694	60.00
65.00	06500	RESPIRATORY THERAPY	0	970,717	65.00
66.00	06600	PHYSICAL THERAPY	-5,942	1,642,569	66.00
67.00	06700	OCCUPATIONAL THERAPY	-372	424,612	67.00
68.00	06800	SPEECH PATHOLOGY	-890,679	-128,843	68.00
69.00	06900	ELECTROCARDIOLOGY	-1,291,882	1,058,016	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-508,133	477,775	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,232,960	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	3,400,526	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,011,851	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	2,290,012	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	450,362	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	407,958	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	596,916	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	797,856	88.02
91.00	09100	EMERGENCY	-3,563,804	4,021,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	3,435,856	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	1,876,814	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-17,788,368	133,735,246	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,664,926	192.00
194.00	07950	WELLNESS	0	191,053	194.00
194.02	07951	LIFELINE	0	157,764	194.02
194.03	07952	OCCUPATIONAL HEALTH	0	593,850	194.03
194.05	07954	MISC. NONREIMBURSABLE	0	1,409,168	194.05
200.00		TOTAL (SUM OF LINES 118-199)	-17,788,368	164,752,007	200.00

RECLASSIFICATIONS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-6
Date/Time Prepared:
11/14/2012 4:15 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,011,851	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
TOTALS			0	7,011,851		
B - RADIOLOGY ADMIN EXPENSES						
1.00	RADIOISOTOPE	56.00	129,035	16,233	1.00	
2.00	CT SCAN	57.00	53,508	10,298	2.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	42,648	2,886	3.00	
TOTALS			225,191	29,417		
C - CAPITAL COSTS: EQUIP RENTAL/COPIERS						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	593,008	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
TOTALS			0	593,008		
D - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,771,193	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	7,021,185	2.00	
TOTALS			0	9,792,378		
E - CAFETERIA						
1.00	CAFETERIA	11.00	691,024	587,447	1.00	
TOTALS			691,024	587,447		
F - EMPLOYEE PHYSICALS						
1.00	EMPLOYEE BENEFITS	4.00	0	142,033	1.00	
TOTALS			0	142,033		
G - EAP BENEFITS						
1.00	EMPLOYEE BENEFITS	4.00	12,497	953	1.00	
TOTALS			12,497	953		
H - PHSN PROF LIABILITY EXP						
1.00	ADULTS & PEDIATRICS	30.00	0	19,056	1.00	
2.00	SUBPROVIDER - IPF	40.00	0	12,056	2.00	
3.00	ANESTHESIOLOGY	53.00	0	409,510	3.00	
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	34,418	4.00	
5.00	LABORATORY	60.00	0	12,056	5.00	
6.00	ELECTROCARDIOLOGY	69.00	0	30,917	6.00	
7.00	EMERGENCY	91.00	0	224,588	7.00	
8.00	RURAL HEALTH CLINIC	88.00	0	16,334	8.00	

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-6
Date/Time Prepared:
11/14/2012 4:15 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
9.00	RURAL HEALTH CLINIC II	88.01	0	21,098	9.00
10.00	RURAL HEALTH CLINIC III	88.02	0	28,390	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	767,098	11.00
	TOTALS		0	1,575,521	
I - W&C - SW SPLIT					
1.00	NURSERY	43.00	360,481	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	547,052	0	2.00
	TOTALS		907,533	0	
J - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,010,815	1.00
	TOTALS		0	1,010,815	
500.00	Grand Total: Increases		1,836,245	20,743,423	500.00

RECLASSIFICATIONS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-6
Date/Time Prepared:
11/14/2012 4:15 pm

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY	15.00	0	7,002,744	0	1.00	
2.00	CORONARY CARE UNIT	32.00	0	117	0	2.00	
3.00	OPERATING ROOM	50.00	0	563	0	3.00	
4.00	RECOVERY ROOM	51.00	0	3,289	0	4.00	
5.00	ANESTHESIOLOGY	53.00	0	2,850	0	5.00	
6.00	ASC (NON-DISTINCT PART)	75.00	0	2,288	0	6.00	
	TOTALS		0	7,011,851			
B - RADIOLOGY ADMIN EXPENSES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	225,191	29,417	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
	TOTALS		225,191	29,417			
C - CAPITAL COSTS: EQUIP RENTAL/COPIERS							
1.00	EMPLOYEE BENEFITS	4.00	0	5,784	14	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	37,650	14	2.00	
3.00	OPERATION OF PLANT	7.00	0	40,685	14	3.00	
4.00	HOUSEKEEPING	9.00	0	60	14	4.00	
5.00	DIETARY	10.00	0	1,463	14	5.00	
6.00	NURSING ADMINISTRATION	13.00	0	3,562	14	6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	21,419	14	7.00	
8.00	PHARMACY	15.00	0	150,895	14	8.00	
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,793	14	9.00	
10.00	ADULTS & PEDIATRICS	30.00	0	9,298	14	10.00	
11.00	CORONARY CARE UNIT	32.00	0	265	14	11.00	
12.00	SUBPROVIDER - IPF	40.00	0	1,779	14	12.00	
13.00	OPERATING ROOM	50.00	0	1,864	14	13.00	
14.00	RECOVERY ROOM	51.00	0	1,274	14	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,207	14	15.00	
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,244	14	16.00	
17.00	LABORATORY	60.00	0	6,892	14	17.00	
18.00	RESPIRATORY THERAPY	65.00	0	3,829	14	18.00	
19.00	PHYSICAL THERAPY	66.00	0	13,765	14	19.00	
20.00	SPEECH PATHOLOGY	68.00	0	952	14	20.00	
21.00	ELECTROCARDIOLOGY	69.00	0	2,846	14	21.00	
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,834	14	22.00	
23.00	ASC (NON-DISTINCT PART)	75.00	0	4,908	14	23.00	
24.00	CARDIAC CATHETERIZATION	59.00	0	1,117	14	24.00	
25.00	EMERGENCY	91.00	0	8,779	14	25.00	
26.00	RURAL HEALTH CLINIC	88.00	0	660	14	26.00	
27.00	RURAL HEALTH CLINIC II	88.01	0	875	14	27.00	
28.00	RURAL HEALTH CLINIC III	88.02	0	676	14	28.00	
29.00	HOME HEALTH AGENCY	101.00	0	13,455	14	29.00	
30.00	HOSPICE	116.00	0	195,847	14	30.00	
31.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	38,033	14	31.00	
32.00	MISC. NONREIMBURSABLE	194.05	0	985	14	32.00	
33.00	OCCUPATIONAL HEALTH	194.03	0	1,313	14	33.00	
	TOTALS		0	593,008			
D - DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,792,378	9	1.00	
2.00		0.00	0	0	9	2.00	
	TOTALS		0	9,792,378			
E - CAFETERIA							
1.00	DIETARY	10.00	691,024	587,447	0	1.00	
	TOTALS		691,024	587,447			
F - EMPLOYEE PHYSICALS							
1.00	OCCUPATIONAL HEALTH	194.03	0	142,033	0	1.00	
	TOTALS		0	142,033			
G - EAP BENEFITS							
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	12,497	953	0	1.00	
	TOTALS		12,497	953			
H - PHSN PROF LIABILITY EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,575,521	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
5.00		0.00	0	0	0	5.00	
6.00		0.00	0	0	0	6.00	
7.00		0.00	0	0	0	7.00	
8.00		0.00	0	0	0	8.00	
9.00		0.00	0	0	0	9.00	
10.00		0.00	0	0	0	10.00	
11.00		0.00	0	0	0	11.00	

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-6
Date/Time Prepared:
11/14/2012 4:15 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	TOTALS		0	1,575,521		
I - W&C - SW SPLIT						
1.00	ADULTS & PEDIATRICS	30.00	907,533	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		907,533	0		
J - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,010,815	11	1.00
	TOTALS		0	1,010,815		
500.00	Grand Total: Decreases		1,836,245	20,743,423		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/14/2012 4:15 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,194,269	0	0	0	0	1.00
2.00	Land Improvements	6,306,299	810,527	0	810,527	18,877	2.00
3.00	Buildings and Fixtures	68,601,787	12,294,579	0	12,294,579	2,151,159	3.00
4.00	Building Improvements	105,832	63,724	0	63,724	0	4.00
5.00	Fixed Equipment	13,954,767	329,042	0	329,042	682,431	5.00
6.00	Movable Equipment	74,951,566	5,791,608	0	5,791,608	9,141,287	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	167,114,520	19,289,480	0	19,289,480	11,993,754	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	167,114,520	19,289,480	0	19,289,480	11,993,754	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
COMPUTATION OF RATIOS					ALLOCATION OF OTHER CAPITAL		
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	90,895,530	0	90,895,530	0.526510	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	83,514,716	1,772,581	81,742,135	0.473490	0	2.00
3.00	Total (sum of lines 1-2)	174,410,246	1,772,581	172,637,665	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/14/2012 4:15 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,194,269	0		1.00		
2.00	Land Improvements	7,097,949	0		2.00		
3.00	Buildings and Fixtures	78,745,207	0		3.00		
4.00	Building Improvements	169,556	0		4.00		
5.00	Fixed Equipment	13,601,378	0		5.00		
6.00	Movable Equipment	71,601,887	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	174,410,246	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	174,410,246	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	0		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,771,193	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	7,021,185	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,792,378	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,771,193	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	593,008	7,614,193	2.00
3.00	Total (sum of lines 1-2)	0	0	0	593,008	10,385,386	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			3.00	4.00
1.00	2.00	3.00	4.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-12,403,323		
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0		
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-701,733	CAFETERIA	11.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts	B	-93,758	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines	B	-2,637	HOUSEKEEPING	9.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	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		SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00 INVESTMENT INCOME	B	-1,010,815	NEW CAP REL COSTS-BLDG & FIXT	1.00 33.00
35.00 A&G OTHER INCOME	B	-221,258	ADMINISTRATIVE & GENERAL	5.00 35.00
36.00 DIETARY OUTREACH REVENUE	B	-9,671	DIETARY	10.00 36.00
37.00 FACILITIES SVC OTHER REV	B	-1,792	OPERATION OF PLANT	7.00 37.00
38.00 W&C OTHER REV (BABY CLASSES)	B	-7,436	ADULTS & PEDIATRICS	30.00 38.00
39.00 XRAY OTHER REVENUE	B	-824	RADIOLOGY-DIAGNOSTIC	54.00 39.00
41.00 PHYSICAL THERAPY OTHER REV	B	-5,942	PHYSICAL THERAPY	66.00 41.00
42.00 OCCUPATIONAL THPY OTR REV	B	-372	OCCUPATIONAL THERAPY	67.00 42.00
43.00 SPEECH/AUDIO OTHER REV	B	-890,679	SPEECH PATHOLOGY	68.00 43.00
44.00 CARDIOLOGY OTHER REV	B	-77,193	ELECTROCARDIOLOGY	69.00 44.00
45.00 EMERGENCY (EMS) OTHER REV	B	-140,113	EMERGENCY	91.00 45.00
45.01 AHA/IHA LOBBYING FEES	A	-25,361	ADMINISTRATIVE & GENERAL	5.00 45.01
45.02 CRNA S&W (EMPLOYEES & LOCUM TENENS)	A	-1,874,365	ANESTHESIOLOGY	53.00 45.02
45.03 CRNA (BENEFIT EXP)	A	-321,096	EMPLOYEE BENEFITS	4.00 45.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-17,788,368		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	INVESTMENT INCOME	11	33.00
35.00	A&G OTHER INCOME	0	35.00
36.00	DIETARY OUTREACH REVENUE	0	36.00
37.00	FACILITIES SVC OTHER REV	0	37.00
38.00	W&C OTHER REV (BABY CLASSES)	0	38.00
39.00	XRAY OTHER REVENUE	0	39.00
41.00	PHYSICAL THERAPY OTHER REV	0	41.00
42.00	OCCUPATIONAL THPY OTR REV	0	42.00
43.00	SPEECH/AUDIO OTHER REV	0	43.00
44.00	CARDIOLOGY OTHER REV	0	44.00
45.00	EMERGENCY (EMS) OTHER REV	0	45.00
45.01	AHA/IHA LOBBYING FEES	0	45.01
45.02	CRNA S&W (EMPLOYEES & LOCUM TENENS)	0	45.02
45.03	CRNA (BENEFIT EXP)	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/14/2012 4:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	ADULTS & PEDIATRICS	669,461	669,461	1.00
2.00	30.00	DR. A	458,028	334,203	2.00
3.00	40.00	SUBPROVIDER - IPF	1,175,555	1,175,555	3.00
4.00	53.00	ANESTHESIOLOGY	2,719,357	2,719,357	4.00
5.00	53.00	DR. B	533,498	274,228	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	1,145,467	1,145,467	6.00
7.00	56.00	RADIOISOTOPE	4,675	4,675	7.00
8.00	60.00	DR. C	392,320	347,081	8.00
9.00	60.00	DR. D	330,982	323,240	9.00
10.00	69.00	ELECTROCARDIOLOGY	1,214,689	1,214,689	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	508,133	508,133	11.00
12.00	91.00	EMERGENCY	3,023,073	3,023,073	12.00
13.00	91.00	DR. E	492,948	248,821	13.00
200.00			12,668,186	11,987,983	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/14/2012 4:15 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	138,700	0	0	0	1.00
2.00	123,825	138,700	598	39,876	1,994	2.00
3.00	0	138,700	0	0	0	3.00
4.00	0	167,500	0	0	0	4.00
5.00	259,270	167,500	988	79,563	3,978	5.00
6.00	0	217,600	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	45,239	208,000	244	24,400	1,220	8.00
9.00	7,742	208,000	52	5,200	260	9.00
10.00	0	150,200	0	0	0	10.00
11.00	0	159,800	0	0	0	11.00
12.00	0	159,800	0	0	0	12.00
13.00	244,127	159,800	1,040	79,900	3,995	13.00
200.00	680,203		2,922	228,939	11,447	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/14/2012 4:15 pm

	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
	12.00	13.00	14.00	15.00	16.00	
1.00	14,604	0	7,000	0	0	1.00
2.00	6,000	1,622	12,056	3,259	44,757	2.00
3.00	14,152	0	12,056	0	0	3.00
4.00	50,874	0	379,370	0	0	4.00
5.00	6,000	2,916	30,140	14,647	97,126	5.00
6.00	3,728	0	34,418	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	1,542	178	6,028	695	25,273	8.00
9.00	1,544	36	6,028	141	5,377	9.00
10.00	9,323	0	30,917	0	0	10.00
11.00	0	0	0	0	0	11.00
12.00	47,446	0	203,490	0	0	12.00
13.00	4,000	1,981	21,098	10,449	92,330	13.00
200.00	159,213	6,733	742,601	29,191	264,863	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/14/2012 4:15 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	669,461	1.00
2.00	79,068	413,271	2.00
3.00	0	1,175,555	3.00
4.00	0	2,719,357	4.00
5.00	162,144	436,372	5.00
6.00	0	1,145,467	6.00
7.00	0	4,675	7.00
8.00	19,966	367,047	8.00
9.00	2,365	325,605	9.00
10.00	0	1,214,689	10.00
11.00	0	508,133	11.00
12.00	0	3,023,073	12.00
13.00	151,797	400,618	13.00
200.00	415,340	12,403,323	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,771,193	2,771,193			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	7,614,193		7,614,193		2.00
4.00 00400	EMPLOYEE BENEFITS	18,660,546	22,725	9,082	18,692,353	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,781,423	398,015	1,808,093	2,273,600	31,261,131
7.00 00700	OPERATION OF PLANT	3,935,564	197,119	131,069	197,350	4,461,102
8.00 00800	LAUNDRY & LINEN SERVICE	459,594	6,598	0	5,638	471,830
9.00 00900	HOUSEKEEPING	1,526,757	57,645	6,829	238,545	1,829,776
10.00 01000	DIETARY	998,283	40,778	37,725	111,340	1,188,126
11.00 01100	CAFETERIA	576,738	24,682	47,780	141,017	790,217
13.00 01300	NURSING ADMINISTRATION	1,354,262	8,803	9,171	246,340	1,618,576
14.00 01400	CENTRAL SERVICES & SUPPLY	920,693	39,629	177,680	76,787	1,214,789
15.00 01500	PHARMACY	1,373,768	18,233	17,033	234,646	1,643,680
16.00 01600	MEDICAL RECORDS & LIBRARY	1,985,192	19,780	8,477	303,782	2,317,231
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,321,889	208,059	312,825	1,675,364	10,518,137
32.00 03200	CORONARY CARE UNIT	1,285,850	27,533	57,985	229,469	1,600,837
40.00 04000	SUBPROVIDER - I/PF	1,276,251	54,153	18,034	452,051	1,800,495
43.00 04300	NURSERY	370,677	3,833	13,185	73,563	461,258
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,632,623	150,085	856,826	593,602	5,233,136
51.00 05100	RECOVERY ROOM	772,014	9,772	41,196	133,864	956,846
52.00 05200	DELIVERY ROOM & LABOR ROOM	617,435	8,741	67,077	111,637	804,890
53.00 05300	ANESTHESIOLOGY	613,118	4,013	101,158	952,253	1,670,542
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,393,670	84,091	1,168,880	320,310	3,966,951
55.00 05500	RADIOLOGY-THERAPEUTIC	1,036,536	42,505	336,961	354,609	1,770,611
56.00 05600	RADIOISOTOPE	1,908,908	12,102	252,490	182,533	2,356,033
57.00 05700	CT SCAN	1,017,439	9,480	367,113	75,693	1,469,725
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	558,235	12,692	313,304	60,329	944,560
59.00 05900	CARDIAC CATHETERIZATION	516,952	17,656	166,295	77,593	778,496
60.00 06000	LABORATORY	8,487,694	55,091	367,142	850,885	9,760,812
65.00 06500	RESPIRATORY THERAPY	970,717	9,598	57,274	151,532	1,189,121
66.00 06600	PHYSICAL THERAPY	1,642,569	89,322	31,084	284,249	2,047,224
67.00 06700	OCCUPATIONAL THERAPY	424,612	2,622	6,776	78,537	512,547
68.00 06800	SPEECH PATHOLOGY	-128,843	19,221	18,016	132,607	41,001
69.00 06900	ELECTROCARDIOLOGY	1,058,016	35,616	165,991	311,177	1,570,800
70.00 07000	ELECTROENCEPHALOGRAPHY	477,775	28,521	36,751	67,533	610,580
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,232,960	0	0	0	3,232,960
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	3,400,526	0	0	0	3,400,526
73.00 07300	DRUGS CHARGED TO PATIENTS	7,011,851	0	0	0	7,011,851
75.00 07500	ASC (NON-DISTINCT PART)	2,290,012	67,237	137,358	280,308	2,774,915
76.00 03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	450,362	16,891	5,375	86,630	559,258
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	407,958	88,489	11,345	59,904	567,696
88.01 08801	RURAL HEALTH CLINIC II	596,916	43,120	1,838	94,108	735,982
88.02 08802	RURAL HEALTH CLINIC III	797,856	17,587	2,113	134,390	951,946
91.00 09100	EMERGENCY	4,021,792	55,812	48,811	1,265,998	5,392,413
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	3,435,856	24,787	4,450	559,155	4,024,248
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	1,876,814	9,319	515	238,282	2,124,930
118.00	SUBTOTALS (SUM OF LINES 1-117)	133,735,246	2,041,955	7,221,107	13,717,216	127,637,785
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	28,664,926	595,430	186,651	4,661,081	34,108,088
194.00 07950	WELLNESS	191,053	0	2,376	19,687	213,116
194.02 07951	LIFELINE	157,764	1,491	0	6,527	165,782
194.03 07952	OCCUPATIONAL HEALTH	593,850	18,084	8,547	119,037	739,518
194.05 07954	MISC. NONREIMBURSABLE	1,409,168	114,233	195,512	168,805	1,887,718
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	164,752,007	2,771,193	7,614,193	18,692,353	164,752,007

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	31,261,131				5.00
7.00	00700	OPERATION OF PLANT	1,044,710	5,505,812			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	110,494	17,735	600,059		8.00
9.00	00900	HOUSEKEEPING	428,501	106,724	0	2,365,001	9.00
10.00	01000	DIETARY	278,238	109,613	6,509	0	1,582,486
11.00	01100	CAFETERIA	185,055	66,346	0	105,260	0
13.00	01300	NURSING ADMINISTRATION	379,041	23,663	0	11,265	0
14.00	01400	CENTRAL SERVICES & SUPPLY	284,482	106,524	18,516	42,245	0
15.00	01500	PHARMACY	384,920	44,002	0	9,505	0
16.00	01600	MEDICAL RECORDS & LIBRARY	542,654	66,980	0	28,515	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,463,158	559,271	208,818	85,546	1,246,608
32.00	03200	CORONARY CARE UNIT	374,887	74,011	17,239	93,290	54,964
40.00	04000	SUBPROVIDER - IPF	421,644	145,567	12,747	99,627	226,316
43.00	04300	NURSERY	108,018	10,303	6,185	4,224	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,225,506	403,435	73,733	231,290	29,824
51.00	05100	RECOVERY ROOM	224,076	26,268	16,162	27,459	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,491	23,496	14,362	0	0
53.00	05300	ANESTHESIOLOGY	391,211	10,788	0	4,577	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	928,989	226,040	59,149	76,041	0
55.00	05500	RADIOLOGY-THERAPEUTIC	414,645	114,256	7,595	61,959	0
56.00	05600	RADIOISOTOPE	551,741	32,530	0	30,627	0
57.00	05700	CT SCAN	344,183	25,483	0	17,954	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	221,199	34,116	0	15,842	0
59.00	05900	CARDIAC CATHETERIZATION	182,310	47,459	3,413	35,556	0
60.00	06000	LABORATORY	2,285,806	148,088	122	85,194	0
65.00	06500	RESPIRATORY THERAPY	278,471	25,800	0	9,505	0
66.00	06600	PHYSICAL THERAPY	479,423	129,034	12,064	70,760	0
67.00	06700	OCCUPATIONAL THERAPY	120,029	0	0	54,214	0
68.00	06800	SPEECH PATHOLOGY	9,602	42,115	28	13,377	0
69.00	06900	ELECTROCARDIOLOGY	367,853	95,736	6,034	43,653	0
70.00	07000	ELECTROENCEPHALOGRAPHY	142,987	76,666	1,285	35,204	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	757,101	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	796,342	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,642,049	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	649,835	180,735	38,576	216,504	0
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	130,968	45,405	0	4,929	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	132,944	237,863	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	172,354	115,909	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	222,929	47,275	0	0	0
91.00	09100	EMERGENCY	1,262,806	150,025	97,472	303,458	24,774
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	942,406	54,706	0	16,546	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	497,620	39,076	0	7,745	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,569,678	3,663,043	600,009	1,841,871	1,582,486
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,987,470	1,483,086	44	428,080	0
194.00	07950	WELLNESS	49,908	0	0	10,209	0
194.02	07951	LIFELINE	38,823	4,008	0	704	0
194.03	07952	OCCUPATIONAL HEALTH	173,182	48,611	6	21,826	0
194.05	07954	MISC. NONREIMBURSABLE	442,070	307,064	0	62,311	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	31,261,131	5,505,812	600,059	2,365,001	1,582,486

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet B Part I Date/Time Prepared: 11/14/2012 4:15 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,146,878					11.00
13.00	01300	24,170	2,056,715				13.00
14.00	01400	14,502	0	1,681,058			14.00
15.00	01500	20,545	0	0	2,102,652		15.00
16.00	01600	48,340	0	0	0	3,003,720	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	203,029	888,460	0	0	175,082	30.00
32.00	03200	22,962	102,269	0	0	20,490	32.00
40.00	04000	27,796	110,385	0	0	30,115	40.00
43.00	04300	8,460	42,562	0	0	10,233	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	66,468	300,839	0	0	161,922	50.00
51.00	05100	13,294	61,908	0	0	32,642	51.00
52.00	05200	12,085	61,649	0	0	27,426	52.00
53.00	05300	22,962	21,211	0	0	62,679	53.00
54.00	05400	36,255	0	0	0	140,941	54.00
55.00	05500	16,919	0	0	0	61,780	55.00
56.00	05600	14,502	0	0	0	123,177	56.00
57.00	05700	7,251	0	0	0	263,225	57.00
58.00	05800	4,834	0	0	0	100,599	58.00
59.00	05900	7,251	0	0	0	17,881	59.00
60.00	06000	106,349	0	0	0	423,081	60.00
65.00	06500	19,336	0	0	0	55,630	65.00
66.00	06600	25,379	0	0	0	52,230	66.00
67.00	06700	6,043	0	0	0	8,279	67.00
68.00	06800	12,085	0	0	0	12,798	68.00
69.00	06900	22,962	0	0	0	35,796	69.00
70.00	07000	9,668	0	0	0	38,918	70.00
71.00	07100	0	0	823,718	0	141,237	71.00
72.00	07200	0	0	857,340	0	94,400	72.00
73.00	07300	0	0	0	2,102,652	355,647	73.00
75.00	07500	31,421	143,740	0	0	173,867	75.00
76.00	03020	13,294	0	0	0	1,594	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	3,223	88.00
88.01	08801	0	0	0	0	3,123	88.01
88.02	08802	0	0	0	0	5,769	88.02
91.00	09100	83,387	323,692	0	0	287,524	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	35,047	0	0	0	39,660	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	4,834	0	0	0	42,752	116.00
118.00		941,430	2,056,715	1,681,058	2,102,652	3,003,720	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	176,443	0	0	0	0	192.00
194.00	07950	3,626	0	0	0	0	194.00
194.02	07951	0	0	0	0	0	194.02
194.03	07952	12,085	0	0	0	0	194.03
194.05	07954	13,294	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,146,878	2,056,715	1,681,058	2,102,652	3,003,720	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	16,348,109	0	16,348,109
32.00	03200	CORONARY CARE UNIT	2,360,949	0	2,360,949
40.00	04000	SUBPROVIDER - IPF	2,874,692	0	2,874,692
43.00	04300	NURSERY	651,243	0	651,243
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,726,153	0	7,726,153
51.00	05100	RECOVERY ROOM	1,358,655	0	1,358,655
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,132,399	0	1,132,399
53.00	05300	ANESTHESIOLOGY	2,183,970	0	2,183,970
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,434,366	0	5,434,366
55.00	05500	RADIOLOGY-THERAPEUTIC	2,447,765	0	2,447,765
56.00	05600	RADIOISOTOPE	3,108,610	0	3,108,610
57.00	05700	CT SCAN	2,127,821	0	2,127,821
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,321,150	0	1,321,150
59.00	05900	CARDIAC CATHETERIZATION	1,072,366	0	1,072,366
60.00	06000	LABORATORY	12,809,452	0	12,809,452
65.00	06500	RESPIRATORY THERAPY	1,577,863	0	1,577,863
66.00	06600	PHYSICAL THERAPY	2,816,114	0	2,816,114
67.00	06700	OCCUPATIONAL THERAPY	701,112	0	701,112
68.00	06800	SPEECH PATHOLOGY	131,006	0	131,006
69.00	06900	ELECTROCARDIOLOGY	2,142,834	0	2,142,834
70.00	07000	ELECTROENCEPHALOGRAPHY	915,308	0	915,308
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,955,016	0	4,955,016
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,148,608	0	5,148,608
73.00	07300	DRUGS CHARGED TO PATIENTS	11,112,199	0	11,112,199
75.00	07500	ASC (NON-DISTINCT PART)	4,209,593	0	4,209,593
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	755,448	0	755,448
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	941,726	0	941,726
88.01	08801	RURAL HEALTH CLINIC II	1,027,368	0	1,027,368
88.02	08802	RURAL HEALTH CLINIC III	1,227,919	0	1,227,919
91.00	09100	EMERGENCY	7,925,551	0	7,925,551
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	5,112,613	0	5,112,613
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	2,716,957	0	2,716,957
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,374,935	0	116,374,935
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,183,211	0	44,183,211
194.00	07950	WELLNESS	276,859	0	276,859
194.02	07951	LIFELINE	209,317	0	209,317
194.03	07952	OCCUPATIONAL HEALTH	995,228	0	995,228
194.05	07954	MISC. NONREIMBURSABLE	2,712,457	0	2,712,457
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	164,752,007	0	164,752,007

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140189

Period: From 07/01/2011 To 06/30/2012

Worksheet B Part II Date/Time Prepared: 11/14/2012 4:15 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	22,725	9,082	31,807	31,807 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	398,015	1,808,093	2,206,108	3,866 5.00
7.00 00700	OPERATION OF PLANT	0	197,119	131,069	328,188	336 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,598	0	6,598	10 8.00
9.00 00900	HOUSEKEEPING	0	57,645	6,829	64,474	406 9.00
10.00 01000	DIETARY	0	40,778	37,725	78,503	189 10.00
11.00 01100	CAFETERIA	0	24,682	47,780	72,462	240 11.00
13.00 01300	NURSING ADMINISTRATION	0	8,803	9,171	17,974	419 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	39,629	177,680	217,309	131 14.00
15.00 01500	PHARMACY	0	18,233	17,033	35,266	399 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	19,780	8,477	28,257	517 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	208,059	312,825	520,884	2,849 30.00
32.00 03200	CORONARY CARE UNIT	0	27,533	57,985	85,518	390 32.00
40.00 04000	SUBPROVIDER - I/PF	0	54,153	18,034	72,187	769 40.00
43.00 04300	NURSERY	0	3,833	13,185	17,018	125 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	150,085	856,826	1,006,911	1,009 50.00
51.00 05100	RECOVERY ROOM	0	9,772	41,196	50,968	228 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	8,741	67,077	75,818	190 52.00
53.00 05300	ANESTHESIOLOGY	0	4,013	101,158	105,171	1,619 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	84,091	1,168,880	1,252,971	545 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	42,505	336,961	379,466	603 55.00
56.00 05600	RADIOISOTOPE	0	12,102	252,490	264,592	310 56.00
57.00 05700	CT SCAN	0	9,480	367,113	376,593	129 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,692	313,304	325,996	103 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	17,656	166,295	183,951	132 59.00
60.00 06000	LABORATORY	0	55,091	367,142	422,233	1,447 60.00
65.00 06500	RESPIRATORY THERAPY	0	9,598	57,274	66,872	258 65.00
66.00 06600	PHYSICAL THERAPY	0	89,322	31,084	120,406	483 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	2,622	6,776	9,398	134 67.00
68.00 06800	SPEECH PATHOLOGY	0	19,221	18,016	37,237	225 68.00
69.00 06900	ELECTROCARDIOLOGY	0	35,616	165,991	201,607	529 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	28,521	36,751	65,272	115 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	67,237	137,358	204,595	477 75.00
76.00 03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	16,891	5,375	22,266	147 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	88,489	11,345	99,834	102 88.00
88.01 08801	RURAL HEALTH CLINIC II	0	43,120	1,838	44,958	160 88.01
88.02 08802	RURAL HEALTH CLINIC III	0	17,587	2,113	19,700	229 88.02
91.00 09100	EMERGENCY	0	55,812	48,811	104,623	2,153 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	24,787	4,450	29,237	951 101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	9,319	515	9,834	405 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,041,955	7,221,107	9,263,062	23,329 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	595,430	186,651	782,081	7,945 192.00
194.00 07950	WELLNESS	0	0	2,376	2,376	33 194.00
194.02 07951	LIFELINE	0	1,491	0	1,491	11 194.02
194.03 07952	OCCUPATIONAL HEALTH	0	18,084	8,547	26,631	202 194.03
194.05 07954	MISC. NONREIMBURSABLE	0	114,233	195,512	309,745	287 194.05
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	2,771,193	7,614,193	10,385,386	31,807 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/14/2012 4:15 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,209,974			5.00
7.00	00700	OPERATION OF PLANT	73,854	402,378		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,811	1,296	15,715	8.00
9.00	00900	HOUSEKEEPING	30,292	7,800	0	102,972
10.00	01000	DIETARY	19,669	8,011	170	0
11.00	01100	CAFETERIA	13,082	4,849	0	4,583
13.00	01300	NURSING ADMINISTRATION	26,796	1,729	0	490
14.00	01400	CENTRAL SERVICES & SUPPLY	20,111	7,785	485	1,839
15.00	01500	PHARMACY	27,211	3,216	0	414
16.00	01600	MEDICAL RECORDS & LIBRARY	38,362	4,895	0	1,242
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	174,128	40,873	5,470	3,725
32.00	03200	CORONARY CARE UNIT	26,502	5,409	451	4,062
40.00	04000	SUBPROVIDER - IPF	29,807	10,638	334	4,338
43.00	04300	NURSERY	7,636	753	162	184
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,635	29,484	1,931	10,070
51.00	05100	RECOVERY ROOM	15,841	1,920	423	1,196
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,325	1,717	376	0
53.00	05300	ANESTHESIOLOGY	27,656	788	0	199
54.00	05400	RADIOLOGY-DIAGNOSTIC	65,673	16,520	1,549	3,311
55.00	05500	RADIOLOGY-THERAPEUTIC	29,312	8,350	199	2,698
56.00	05600	RADIOISOTOPE	39,004	2,377	0	1,334
57.00	05700	CT SCAN	24,331	1,862	0	782
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,637	2,493	0	690
59.00	05900	CARDIAC CATHETERIZATION	12,888	3,468	89	1,548
60.00	06000	LABORATORY	161,590	10,823	3	3,709
65.00	06500	RESPIRATORY THERAPY	19,686	1,886	0	414
66.00	06600	PHYSICAL THERAPY	33,892	9,430	316	3,081
67.00	06700	OCCUPATIONAL THERAPY	8,485	0	0	2,360
68.00	06800	SPEECH PATHOLOGY	679	3,078	1	582
69.00	06900	ELECTROCARDIOLOGY	26,005	6,997	158	1,901
70.00	07000	ELECTROENCEPHALOGRAPHY	10,108	5,603	34	1,533
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,522	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	56,296	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	116,081	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	45,939	13,209	1,010	9,427
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,259	3,318	0	215
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,398	17,384	0	0
88.01	08801	RURAL HEALTH CLINIC II	12,184	8,471	0	0
88.02	08802	RURAL HEALTH CLINIC III	15,759	3,455	0	0
91.00	09100	EMERGENCY	89,271	10,964	2,553	13,213
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				1,668
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	66,621	3,998	0	720
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	35,178	2,856	0	337
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,595,516	267,705	15,714	80,197
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	564,691	108,386	1	18,636
194.00	07950	WELLNESS	3,528	0	0	445
194.02	07951	LIFELINE	2,745	293	0	31
194.03	07952	OCCUPATIONAL HEALTH	12,243	3,553	0	950
194.05	07954	MISC. NONREIMBURSABLE	31,251	22,441	0	2,713
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,209,974	402,378	15,715	102,972

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/14/2012 4:15 pm
-------------------------------------	--	----------------------	---------------------------------------------	---------------------------------------------------------------------

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	95,216					11.00
13.00	01300	2,007	49,415				13.00
14.00	01400	1,204	0	248,864			14.00
15.00	01500	1,706	0	0	68,212		15.00
16.00	01600	4,013	0	0	0	77,286	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	16,856	21,346	0	0	4,495	30.00
32.00	03200	1,906	2,457	0	0	526	32.00
40.00	04000	2,308	2,652	0	0	773	40.00
43.00	04300	702	1,023	0	0	263	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,518	7,228	0	0	4,157	50.00
51.00	05100	1,104	1,487	0	0	838	51.00
52.00	05200	1,003	1,481	0	0	704	52.00
53.00	05300	1,906	510	0	0	1,609	53.00
54.00	05400	3,010	0	0	0	3,619	54.00
55.00	05500	1,405	0	0	0	1,586	55.00
56.00	05600	1,204	0	0	0	3,163	56.00
57.00	05700	602	0	0	0	6,758	57.00
58.00	05800	401	0	0	0	2,583	58.00
59.00	05900	602	0	0	0	459	59.00
60.00	06000	8,829	0	0	0	11,029	60.00
65.00	06500	1,605	0	0	0	1,428	65.00
66.00	06600	2,107	0	0	0	1,341	66.00
67.00	06700	502	0	0	0	213	67.00
68.00	06800	1,003	0	0	0	329	68.00
69.00	06900	1,906	0	0	0	919	69.00
70.00	07000	803	0	0	0	999	70.00
71.00	07100	0	0	121,943	0	3,626	71.00
72.00	07200	0	0	126,921	0	2,424	72.00
73.00	07300	0	0	0	68,212	9,131	73.00
75.00	07500	2,609	3,454	0	0	4,464	75.00
76.00	03020	1,104	0	0	0	41	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	83	88.00
88.01	08801	0	0	0	0	80	88.01
88.02	08802	0	0	0	0	148	88.02
91.00	09100	6,923	7,777	0	0	7,382	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	2,910	0	0	0	1,018	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	401	0	0	0	1,098	116.00
118.00		78,159	49,415	248,864	68,212	77,286	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	14,649	0	0	0	0	192.00
194.00	07950	301	0	0	0	0	194.00
194.02	07951	0	0	0	0	0	194.02
194.03	07952	1,003	0	0	0	0	194.03
194.05	07954	1,104	0	0	0	0	194.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		95,216	49,415	248,864	68,212	77,286	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	874,555	0	874,555	30.00
32.00	03200	130,921	0	130,921	32.00
40.00	04000	139,043	0	139,043	40.00
43.00	04300	27,866	0	27,866	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,154,951	0	1,154,951	50.00
51.00	05100	74,005	0	74,005	51.00
52.00	05200	94,614	0	94,614	52.00
53.00	05300	139,458	0	139,458	53.00
54.00	05400	1,347,198	0	1,347,198	54.00
55.00	05500	423,619	0	423,619	55.00
56.00	05600	311,984	0	311,984	56.00
57.00	05700	411,057	0	411,057	57.00
58.00	05800	347,903	0	347,903	58.00
59.00	05900	203,137	0	203,137	59.00
60.00	06000	619,663	0	619,663	60.00
65.00	06500	92,149	0	92,149	65.00
66.00	06600	171,056	0	171,056	66.00
67.00	06700	21,092	0	21,092	67.00
68.00	06800	43,134	0	43,134	68.00
69.00	06900	240,022	0	240,022	69.00
70.00	07000	84,467	0	84,467	70.00
71.00	07100	179,091	0	179,091	71.00
72.00	07200	185,641	0	185,641	72.00
73.00	07300	193,424	0	193,424	73.00
75.00	07500	285,184	0	285,184	75.00
76.00	03020	36,350	0	36,350	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	126,801	0	126,801	88.00
88.01	08801	65,853	0	65,853	88.01
88.02	08802	39,291	0	39,291	88.02
91.00	09100	246,527	0	246,527	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	105,455	0	105,455	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	50,109	0	50,109	116.00
118.00		8,465,620	0	8,465,620	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	1,496,389	0	1,496,389	192.00
194.00	07950	6,683	0	6,683	194.00
194.02	07951	4,571	0	4,571	194.02
194.03	07952	44,582	0	44,582	194.03
194.05	07954	367,541	0	367,541	194.05
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		10,385,386	0	10,385,386	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	446,076					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		6,195,845				2.00
4.00 00400	EMPLOYEE BENEFITS	3,658	7,390	91,597,938			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	64,068	1,471,285	11,141,277	-31,261,131	133,490,876	5.00
7.00 00700	OPERATION OF PLANT	31,730	106,654	967,071	0	4,461,102	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,062	0	27,630	0	471,830	8.00
9.00 00900	HOUSEKEEPING	9,279	5,557	1,168,937	0	1,829,776	9.00
10.00 01000	DIETARY	6,564	30,698	545,598	0	1,188,126	10.00
11.00 01100	CAFETERIA	3,973	38,880	691,024	0	790,217	11.00
13.00 01300	NURSING ADMINISTRATION	1,417	7,463	1,207,137	0	1,618,576	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,379	144,582	376,279	0	1,214,789	14.00
15.00 01500	PHARMACY	2,935	13,860	1,149,832	0	1,643,680	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,184	6,898	1,488,618	0	2,317,231	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	33,491	254,553	8,209,752	0	10,518,137	30.00
32.00 03200	CORONARY CARE UNIT	4,432	47,184	1,124,462	0	1,600,837	32.00
40.00 04000	SUBPROVIDER - I/PF	8,717	14,675	2,215,207	0	1,800,495	40.00
43.00 04300	NURSERY	617	10,729	360,481	0	461,258	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	24,159	697,219	2,908,817	0	5,233,136	50.00
51.00 05100	RECOVERY ROOM	1,573	33,522	655,971	0	956,846	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,407	54,582	547,052	0	804,890	52.00
53.00 05300	ANESTHESIOLOGY	646	82,315	4,666,305	0	1,670,542	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,536	951,145	1,569,610	0	3,966,951	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	6,842	274,193	1,737,685	0	1,770,611	55.00
56.00 05600	RADIOISOTOPE	1,948	205,457	894,463	0	2,356,033	56.00
57.00 05700	CT SCAN	1,526	298,728	370,915	0	1,469,725	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	2,043	254,943	295,631	0	944,560	58.00
59.00 05900	CARDIAC CATHETERIZATION	2,842	135,318	380,228	0	778,496	59.00
60.00 06000	LABORATORY	8,868	298,752	4,169,575	0	9,760,812	60.00
65.00 06500	RESPIRATORY THERAPY	1,545	46,605	742,549	0	1,189,121	65.00
66.00 06600	PHYSICAL THERAPY	14,378	25,294	1,392,898	0	2,047,224	66.00
67.00 06700	OCCUPATIONAL THERAPY	422	5,514	384,853	0	512,547	67.00
68.00 06800	SPEECH PATHOLOGY	3,094	14,660	649,810	0	41,001	68.00
69.00 06900	ELECTROCARDIOLOGY	5,733	135,071	1,524,856	0	1,570,800	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	4,591	29,905	330,929	0	610,580	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,232,960	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	3,400,526	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,011,851	73.00
75.00 07500	ASC (NON-DISTINCT PART)	10,823	111,771	1,373,589	0	2,774,915	75.00
76.00 03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	4,374	424,510	0	559,258	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	14,244	9,232	293,545	0	567,696	88.00
88.01 08801	RURAL HEALTH CLINIC II	6,941	1,496	461,155	0	735,982	88.01
88.02 08802	RURAL HEALTH CLINIC III	2,831	1,719	658,550	0	951,946	88.02
91.00 09100	EMERGENCY	8,984	39,719	6,203,742	0	5,392,413	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	3,990	3,621	2,740,015	0	4,024,248	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 11600	HOSPICE	1,500	419	1,167,649	0	2,124,930	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	328,691	5,875,982	67,218,207	-31,261,131	96,376,654	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	95,846	151,882	22,840,767	0	34,108,088	192.00
194.00 07950	WELLNESS	0	1,933	96,474	0	213,116	194.00
194.02 07951	LIFELINE	240	0	31,982	0	165,782	194.02
194.03 07952	OCCUPATIONAL HEALTH	2,911	6,955	583,316	0	739,518	194.03
194.05 07954	MISC. NONREIMBURSABLE	18,388	159,093	827,192	0	1,887,718	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,771,193	7,614,193	18,692,353		31,261,131	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.212379	1.228919	0.204070		0.234182	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			31,807		2,209,974	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000347		0.016555	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	329,706				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	710,519			8.00
9.00	00900	HOUSEKEEPING	6,391	0	6,718		9.00
10.00	01000	DIETARY	6,564	7,707	0	125,646	10.00
11.00	01100	CAFETERIA	3,973	0	299	0	949 11.00
13.00	01300	NURSING ADMINISTRATION	1,417	0	32	0	20 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,379	21,924	120	0	12 14.00
15.00	01500	PHARMACY	2,635	0	27	0	17 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,011	0	81	0	40 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	33,491	247,259	243	98,978	168 30.00
32.00	03200	CORONARY CARE UNIT	4,432	20,412	265	4,364	19 32.00
40.00	04000	SUBPROVIDER - I/PF	8,717	15,093	283	17,969	23 40.00
43.00	04300	NURSERY	617	7,324	12	0	7 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,159	87,306	657	2,368	55 50.00
51.00	05100	RECOVERY ROOM	1,573	19,137	78	0	11 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	17,006	0	0	10 52.00
53.00	05300	ANESTHESIOLOGY	646	0	13	0	19 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,536	70,037	216	0	30 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,842	8,993	176	0	14 55.00
56.00	05600	RADIOISOTOPE	1,948	0	87	0	12 56.00
57.00	05700	CT SCAN	1,526	0	51	0	6 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,043	0	45	0	4 58.00
59.00	05900	CARDIAC CATHETERIZATION	2,842	4,041	101	0	6 59.00
60.00	06000	LABORATORY	8,868	144	242	0	88 60.00
65.00	06500	RESPIRATORY THERAPY	1,545	0	27	0	16 65.00
66.00	06600	PHYSICAL THERAPY	7,727	14,285	201	0	21 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	154	0	5 67.00
68.00	06800	SPEECH PATHOLOGY	2,522	33	38	0	10 68.00
69.00	06900	ELECTROCARDIOLOGY	5,733	7,145	124	0	19 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	1,522	100	0	8 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	10,823	45,677	615	0	26 75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	0	14	0	11 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,244	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	6,941	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	2,831	0	0	0	0 88.02
91.00	09100	EMERGENCY	8,984	115,415	862	1,967	69 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,276	0	47	0	29 101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	2,340	0	22	0	4 116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	219,355	710,460	5,232	125,646	779 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,812	52	1,216	0	146 192.00
194.00	07950	WELLNESS	0	0	29	0	3 194.00
194.02	07951	LIFELINE	240	0	2	0	0 194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	7	62	0	10 194.03
194.05	07954	MISC. NONREIMBURSABLE	18,388	0	177	0	11 194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,505,812	600,059	2,365,001	1,582,486	1,146,878 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.699156	0.844536	352.039446	12.594798	1,208.512118 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	402,378	15,715	102,972	106,542	95,216 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.220415	0.022118	15.327776	0.847954	100.332982 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	692,520				13.00
14.00	01400	0	100			14.00
15.00	01500	0	0	100		15.00
16.00	01600	0	0	0	403,758,374	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	299,155	0	0	23,535,668	30.00
32.00	03200	34,435	0	0	2,754,391	32.00
40.00	04000	37,168	0	0	4,048,231	40.00
43.00	04300	14,331	0	0	1,375,523	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	101,296	0	0	21,766,701	50.00
51.00	05100	20,845	0	0	4,387,890	51.00
52.00	05200	20,758	0	0	3,686,759	52.00
53.00	05300	7,142	0	0	8,425,703	53.00
54.00	05400	0	0	0	18,946,262	54.00
55.00	05500	0	0	0	8,304,861	55.00
56.00	05600	0	0	0	16,558,234	56.00
57.00	05700	0	0	0	35,384,459	57.00
58.00	05800	0	0	0	13,523,139	58.00
59.00	05900	0	0	0	2,403,743	59.00
60.00	06000	0	0	0	56,851,805	60.00
65.00	06500	0	0	0	7,478,175	65.00
66.00	06600	0	0	0	7,021,121	66.00
67.00	06700	0	0	0	1,112,980	67.00
68.00	06800	0	0	0	1,720,389	68.00
69.00	06900	0	0	0	4,811,890	69.00
70.00	07000	0	0	0	5,231,565	70.00
71.00	07100	0	49	0	18,986,015	71.00
72.00	07200	0	51	0	12,689,911	72.00
73.00	07300	0	0	100	47,808,468	73.00
75.00	07500	48,399	0	0	23,372,362	75.00
76.00	03020	0	0	0	214,258	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	433,249	88.00
88.01	08801	0	0	0	419,813	88.01
88.02	08802	0	0	0	775,481	88.02
91.00	09100	108,991	0	0	38,650,959	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0	0	0	5,331,320	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	0	0	0	5,747,049	116.00
118.00		692,520	100	100	403,758,374	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.02	07951	0	0	0	0	194.02
194.03	07952	0	0	0	0	194.03
194.05	07954	0	0	0	0	194.05
200.00						200.00
201.00						201.00
202.00		2,056,715	1,681,058	2,102,652	3,003,720	202.00
203.00		2.969900	16,810.580000	21,026.520000	0.007439	203.00
204.00		49,415	248,864	68,212	77,286	204.00
205.00		0.071355	2,488.640000	682.120000	0.000191	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet C Part I Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	16,348,109		16,348,109	79,068	16,427,177	30.00
32.00	03200 CORONARY CARE UNIT	2,360,949		2,360,949	0	2,360,949	32.00
40.00	04000 SUBPROVIDER - I/PF	2,874,692		2,874,692	0	2,874,692	40.00
43.00	04300 NURSERY	651,243		651,243	0	651,243	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	7,726,153		7,726,153	0	7,726,153	50.00
51.00	05100 RECOVERY ROOM	1,358,655		1,358,655	0	1,358,655	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,132,399		1,132,399	0	1,132,399	52.00
53.00	05300 ANESTHESIOLOGY	2,183,970		2,183,970	162,144	2,346,114	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,434,366		5,434,366	0	5,434,366	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	2,447,765		2,447,765	0	2,447,765	55.00
56.00	05600 RADIOISOTOPE	3,108,610		3,108,610	0	3,108,610	56.00
57.00	05700 CT SCAN	2,127,821		2,127,821	0	2,127,821	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,321,150		1,321,150	0	1,321,150	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,072,366		1,072,366	0	1,072,366	59.00
60.00	06000 LABORATORY	12,809,452		12,809,452	22,331	12,831,783	60.00
65.00	06500 RESPIRATORY THERAPY	1,577,863	0	1,577,863	0	1,577,863	65.00
66.00	06600 PHYSICAL THERAPY	2,816,114	0	2,816,114	0	2,816,114	66.00
67.00	06700 OCCUPATIONAL THERAPY	701,112	0	701,112	0	701,112	67.00
68.00	06800 SPEECH PATHOLOGY	131,006	0	131,006	0	131,006	68.00
69.00	06900 ELECTROCARDIOLOGY	2,142,834		2,142,834	0	2,142,834	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	915,308		915,308	0	915,308	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,955,016		4,955,016	0	4,955,016	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,148,608		5,148,608	0	5,148,608	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11,112,199		11,112,199	0	11,112,199	73.00
75.00	07500 ASC (NON-DISTINCT PART)	4,209,593		4,209,593	0	4,209,593	75.00
76.00	03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	755,448		755,448	0	755,448	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	941,726		941,726	0	941,726	88.00
88.01	08801 RURAL HEALTH CLINIC II	1,027,368		1,027,368	0	1,027,368	88.01
88.02	08802 RURAL HEALTH CLINIC III	1,227,919		1,227,919	0	1,227,919	88.02
91.00	09100 EMERGENCY	7,925,551		7,925,551	151,797	8,077,348	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,628,114		2,628,114		2,628,114	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	5,112,613		5,112,613		5,112,613	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPICE	2,716,957		2,716,957		2,716,957	116.00
200.00	Subtotal (see instructions)	119,003,049	0	119,003,049	415,340	119,418,389	200.00
201.00	Less Observation Beds	2,628,114		2,628,114		2,628,114	201.00
202.00	Total (see instructions)	116,374,935	0	116,374,935	415,340	116,790,275	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet C Part I Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVII I		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,006,772		19,006,772		30.00
32.00	03200	CORONARY CARE UNIT	2,754,391		2,754,391		32.00
40.00	04000	SUBPROVIDER - IPF	4,048,231		4,048,231		40.00
43.00	04300	NURSERY	1,375,523		1,375,523		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,337,788	12,428,913	21,766,701	0.354953	50.00
51.00	05100	RECOVERY ROOM	1,483,492	2,904,398	4,387,890	0.309637	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,494,812	191,947	3,686,759	0.307153	52.00
53.00	05300	ANESTHESIOLOGY	2,651,960	5,773,743	8,425,703	0.259203	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,197,122	15,749,140	18,946,262	0.286831	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	205,022	8,099,839	8,304,861	0.294739	55.00
56.00	05600	RADIOISOTOPE	2,467,008	14,091,226	16,558,234	0.187738	56.00
57.00	05700	CT SCAN	7,241,868	28,142,591	35,384,459	0.060134	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	974,271	12,548,868	13,523,139	0.097696	58.00
59.00	05900	CARDIAC CATHETERIZATION	605,032	1,798,711	2,403,743	0.446123	59.00
60.00	06000	LABORATORY	11,599,069	45,252,736	56,851,805	0.225313	60.00
65.00	06500	RESPIRATORY THERAPY	6,003,793	1,474,382	7,478,175	0.210996	65.00
66.00	06600	PHYSICAL THERAPY	666,122	6,354,999	7,021,121	0.401092	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,246	936,734	1,112,980	0.629941	67.00
68.00	06800	SPEECH PATHOLOGY	150,809	1,569,580	1,720,389	0.076149	68.00
69.00	06900	ELECTROCARDIOLOGY	1,094,402	3,717,488	4,811,890	0.445321	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,235	5,198,330	5,231,565	0.174959	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,900,148	12,085,867	18,986,015	0.260982	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	9,580,582	3,109,329	12,689,911	0.405725	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,014,569	27,793,899	47,808,468	0.232432	73.00
75.00	07500	ASC (NON-DISTINCT PART)	204,831	23,167,531	23,372,362	0.180110	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	214,258	214,258	3.525880	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	433,249	433,249		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	419,813	419,813		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	775,481	775,481		88.02
91.00	09100	EMERGENCY	8,558,325	30,092,634	38,650,959	0.205054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,528,896	4,528,896	0.580299	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	5,331,320	5,331,320		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	5,747,049	5,747,049		116.00
200.00		Subtotal (see instructions)	123,825,423	279,932,951	403,758,374		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	123,825,423	279,932,951	403,758,374		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/14/2012 4:15 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
32.00	03200 CORONARY CARE UNIT			32.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.354953		50.00
51.00	05100 RECOVERY ROOM	0.309637		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.307153		52.00
53.00	05300 ANESTHESIOLOGY	0.278447		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.286831		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.294739		55.00
56.00	05600 RADIOISOTOPE	0.187738		56.00
57.00	05700 CT SCAN	0.060134		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.097696		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.446123		59.00
60.00	06000 LABORATORY	0.225706		60.00
65.00	06500 RESPIRATORY THERAPY	0.210996		65.00
66.00	06600 PHYSICAL THERAPY	0.401092		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.629941		67.00
68.00	06800 SPEECH PATHOLOGY	0.076149		68.00
69.00	06900 ELECTROCARDIOLOGY	0.445321		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.174959		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260982		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.405725		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.232432		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.180110		75.00
76.00	03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.525880		76.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
88.01	08801 RURAL HEALTH CLINIC II			88.01
88.02	08802 RURAL HEALTH CLINIC III			88.02
91.00	09100 EMERGENCY	0.208982		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.580299		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part I Date/Time Prepared: 11/14/2012 4:15 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	874,555	0	874,555	21,827	40.07	30.00
32.00	03200	CORONARY CARE UNIT	130,921		130,921	1,658	78.96	32.00
40.00	04000	SUBPROVIDER - IPF	139,043	0	139,043	3,846	36.15	40.00
43.00	04300	NURSERY	27,866		27,866	1,210	23.03	43.00
200.00		Total (lines 30-199)	1,172,385		1,172,385	28,541		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part I Date/Time Prepared: 11/14/2012 4:15 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII	Hospital	PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,200	448,784			30.00
32.00	03200	CORONARY CARE UNIT	1,017	80,302			32.00
40.00	04000	SUBPROVIDER - I/PF	1,379	49,851			40.00
43.00	04300	NURSERY	0	0			43.00
200.00		Total (lines 30-199)	13,596	578,937			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet D
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,154,951	21,766,701	0.053060	4,706,469	249,725	50.00
51.00	05100	RECOVERY ROOM	74,005	4,387,890	0.016866	530,184	8,942	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	94,614	3,686,759	0.025663	7,993	205	52.00
53.00	05300	ANESTHESIOLOGY	139,458	8,425,703	0.016551	1,118,234	18,508	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,347,198	18,946,262	0.071106	2,347,950	166,953	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	423,619	8,304,861	0.051009	87,740	4,476	55.00
56.00	05600	RADIOISOTOPE	311,984	16,558,234	0.018842	1,442,440	27,178	56.00
57.00	05700	CT SCAN	411,057	35,384,459	0.011617	4,437,787	51,554	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	347,903	13,523,139	0.025726	587,148	15,105	58.00
59.00	05900	CARDIAC CATHETERIZATION	203,137	2,403,743	0.084509	226,362	19,130	59.00
60.00	06000	LABORATORY	619,663	56,851,805	0.010900	7,054,788	76,897	60.00
65.00	06500	RESPIRATORY THERAPY	92,149	7,478,175	0.012322	3,563,813	43,913	65.00
66.00	06600	PHYSICAL THERAPY	171,056	7,021,121	0.024363	430,194	10,481	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,092	1,112,980	0.018951	117,477	2,226	67.00
68.00	06800	SPEECH PATHOLOGY	43,134	1,720,389	0.025072	75,621	1,896	68.00
69.00	06900	ELECTROCARDIOLOGY	240,022	4,811,890	0.049881	562,775	28,072	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84,467	5,231,565	0.016146	15,500	250	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,091	18,986,015	0.009433	3,457,150	32,611	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	185,641	12,689,911	0.014629	5,238,311	76,631	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	193,424	47,808,468	0.004046	11,226,572	45,423	73.00
75.00	07500	ASC (NON-DISTINCT PART)	285,184	23,372,362	0.012202	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,350	214,258	0.169655	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	126,801	433,249	0.292675	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	65,853	419,813	0.156863	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	39,291	775,481	0.050667	0	0	88.02
91.00	09100	EMERGENCY	246,527	38,650,959	0.006378	1,695,811	10,816	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	139,916	4,528,896	0.030894	0	0	92.00
200.00		Total (lines 50-199)	7,277,587	365,495,088		48,930,319	890,992	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/14/2012 4:15 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/14/2012 4:15 pm	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	PPS
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,827	0.00	11,200	0	0	30.00
32.00	03200	CORONARY CARE UNIT	1,658	0.00	1,017	0	0	32.00
40.00	04000	SUBPROVIDER - IPF	3,846	0.00	1,379	0	0	40.00
43.00	04300	NURSERY	1,210	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	28,541		13,596	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/14/2012 4:15 pm	
Cost Center Description		PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS	
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
32.00	03200	CORONARY CARE UNIT	0	0			32.00
40.00	04000	SUBPROVIDER - I PF	0	0			40.00
43.00	04300	NURSERY	0	0			43.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00	
57.00	05700	CT SCAN	0	0	0	0	0 57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00	
60.00	06000	LABORATORY	0	0	0	0	0 60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00	
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02	
91.00	09100	EMERGENCY	0	0	0	0	0 91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00	
200.00		Total (lines 50-199)	0	0	0	0	0 200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	21,766,701	0.000000	0.000000	4,706,469	50.00
51.00	05100	RECOVERY ROOM	0	4,387,890	0.000000	0.000000	530,184	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,686,759	0.000000	0.000000	7,993	52.00
53.00	05300	ANESTHESIOLOGY	0	8,425,703	0.000000	0.000000	1,118,234	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,946,262	0.000000	0.000000	2,347,950	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	8,304,861	0.000000	0.000000	87,740	55.00
56.00	05600	RADIOISOTOPE	0	16,558,234	0.000000	0.000000	1,442,440	56.00
57.00	05700	CT SCAN	0	35,384,459	0.000000	0.000000	4,437,787	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	13,523,139	0.000000	0.000000	587,148	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,403,743	0.000000	0.000000	226,362	59.00
60.00	06000	LABORATORY	0	56,851,805	0.000000	0.000000	7,054,788	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,478,175	0.000000	0.000000	3,563,813	65.00
66.00	06600	PHYSICAL THERAPY	0	7,021,121	0.000000	0.000000	430,194	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,112,980	0.000000	0.000000	117,477	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,720,389	0.000000	0.000000	75,621	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,811,890	0.000000	0.000000	562,775	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,231,565	0.000000	0.000000	15,500	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,986,015	0.000000	0.000000	3,457,150	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	12,689,911	0.000000	0.000000	5,238,311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	47,808,468	0.000000	0.000000	11,226,572	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	23,372,362	0.000000	0.000000	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	214,258	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	433,249	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	419,813	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	775,481	0.000000	0.000000	0	88.02
91.00	09100	EMERGENCY	0	38,650,959	0.000000	0.000000	1,695,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,528,896	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	365,495,088			48,930,319	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		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	05000	OPERATING ROOM	0	9,981,371	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,059,005	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,108	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,795,140	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,985,865	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,284,189	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	3,656,483	0	0	0	56.00
57.00	05700	CT SCAN	0	9,197,721	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,635,796	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	824,920	0	0	0	59.00
60.00	06000	LABORATORY	0	1,859,951	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	618,886	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	153,027	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	213,288	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,548,920	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,449,259	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,438,569	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,378,710	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,763,427	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	7,567,347	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,128,431	0	0	0	92.00
200.00		Total (lines 50-199)	0	71,543,413	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/14/2012 4:15 pm
	Title XVIII	Hospital	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0	88.02
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS		
		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	05000	OPERATING ROOM	0.354953	9,981,371	0	0	50.00
51.00	05100	RECOVERY ROOM	0.309637	1,059,005	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307153	3,108	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.259203	1,795,140	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286831	4,985,865	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.294739	3,284,189	0	0	55.00
56.00	05600	RADIOISOTOPE	0.187738	3,656,483	0	0	56.00
57.00	05700	CT SCAN	0.060134	9,197,721	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.097696	3,635,796	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.446123	824,920	0	0	59.00
60.00	06000	LABORATORY	0.225313	1,859,951	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.210996	618,886	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.401092	153,027	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.629941	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.076149	213,288	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.445321	1,548,920	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174959	1,449,259	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260982	2,438,569	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.405725	1,378,710	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232432	13,763,427	55	29,553	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.180110	0	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.525880	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				88.02
91.00	09100	EMERGENCY	0.205054	7,567,347	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.580299	2,128,431	832	0	92.00
200.00		Subtotal (see instructions)		71,543,413	887	29,553	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		71,543,413	887	29,553	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			Hospital	PPS	
	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	05000	OPERATING ROOM	3,542,918	0	0	50.00
51.00	05100	RECOVERY ROOM	327,907	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	955	0	0	52.00
53.00	05300	ANESTHESIOLOGY	465,306	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,430,101	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	967,979	0	0	55.00
56.00	05600	RADIOISOTOPE	686,461	0	0	56.00
57.00	05700	CT SCAN	553,096	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	355,203	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	368,016	0	0	59.00
60.00	06000	LABORATORY	419,071	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	130,582	0	0	65.00
66.00	06600	PHYSICAL THERAPY	61,378	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,242	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	689,767	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	253,561	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	636,423	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	559,377	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,199,061	13	6,869	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	88.02
91.00	09100	EMERGENCY	1,551,715	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,235,126	483	0	92.00
200.00		Subtotal (see instructions)	17,450,245	496	6,869	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	17,450,245	496	6,869	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140189 Component CCN: 14S189		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part II Date/Time Prepared: 11/14/2012 4:15 pm	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,154,951	21,766,701	0.053060	4,289	228 50.00
51.00	05100	RECOVERY ROOM	74,005	4,387,890	0.016866	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	94,614	3,686,759	0.025663	0	0 52.00
53.00	05300	ANESTHESIOLOGY	139,458	8,425,703	0.016551	852	14 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,347,198	18,946,262	0.071106	10,840	771 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	423,619	8,304,861	0.051009	0	0 55.00
56.00	05600	RADIOISOTOPE	311,984	16,558,234	0.018842	7,097	134 56.00
57.00	05700	CT SCAN	411,057	35,384,459	0.011617	48,726	566 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	347,903	13,523,139	0.025726	12,560	323 58.00
59.00	05900	CARDIAC CATHETERIZATION	203,137	2,403,743	0.084509	0	0 59.00
60.00	06000	LABORATORY	619,663	56,851,805	0.010900	317,502	3,461 60.00
65.00	06500	RESPIRATORY THERAPY	92,149	7,478,175	0.012322	89,162	1,099 65.00
66.00	06600	PHYSICAL THERAPY	171,056	7,021,121	0.024363	2,620	64 66.00
67.00	06700	OCCUPATIONAL THERAPY	21,092	1,112,980	0.018951	1,464	28 67.00
68.00	06800	SPEECH PATHOLOGY	43,134	1,720,389	0.025072	136	3 68.00
69.00	06900	ELECTROCARDIOLOGY	240,022	4,811,890	0.049881	8,837	441 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84,467	5,231,565	0.016146	4,157	67 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,091	18,986,015	0.009433	9,665	91 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	185,641	12,689,911	0.014629	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	193,424	47,808,468	0.004046	509,172	2,060 73.00
75.00	07500	ASC (NON-DISTINCT PART)	285,184	23,372,362	0.012202	0	0 75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,350	214,258	0.169655	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	126,801	433,249	0.292675	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	65,853	419,813	0.156863	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	39,291	775,481	0.050667	0	0 88.02
91.00	09100	EMERGENCY	246,527	38,650,959	0.006378	241,975	1,543 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	139,916	4,528,896	0.030894	0	0 92.00
200.00		Total (lines 50-199)	7,277,587	365,495,088		1,269,054	10,893 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/14/2012 4:15 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/14/2012 4:15 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		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	05000 OPERATING ROOM	0	21,766,701	0.000000	0.000000	4,289	50.00
51.00	05100 RECOVERY ROOM	0	4,387,890	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,686,759	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	8,425,703	0.000000	0.000000	852	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	18,946,262	0.000000	0.000000	10,840	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	8,304,861	0.000000	0.000000	0	55.00
56.00	05600 RADIOISOTOPE	0	16,558,234	0.000000	0.000000	7,097	56.00
57.00	05700 CT SCAN	0	35,384,459	0.000000	0.000000	48,726	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	13,523,139	0.000000	0.000000	12,560	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,403,743	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	56,851,805	0.000000	0.000000	317,502	60.00
65.00	06500 RESPIRATORY THERAPY	0	7,478,175	0.000000	0.000000	89,162	65.00
66.00	06600 PHYSICAL THERAPY	0	7,021,121	0.000000	0.000000	2,620	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,112,980	0.000000	0.000000	1,464	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,720,389	0.000000	0.000000	136	68.00
69.00	06900 ELECTROCARDIOLOGY	0	4,811,890	0.000000	0.000000	8,837	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	5,231,565	0.000000	0.000000	4,157	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,986,015	0.000000	0.000000	9,665	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	12,689,911	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	47,808,468	0.000000	0.000000	509,172	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	23,372,362	0.000000	0.000000	0	75.00
76.00	03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	214,258	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	433,249	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	419,813	0.000000	0.000000	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	775,481	0.000000	0.000000	0	88.02
91.00	09100 EMERGENCY	0	38,650,959	0.000000	0.000000	241,975	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,528,896	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	0	365,495,088			1,269,054	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/14/2012 4:15 pm
	Component CCN: 14S189	Title XVIII	Subprovider - IPF PPS

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/14/2012 4:15 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03020 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	88.02
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/14/2012 4:15 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		21,827	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		21,827	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		18,335	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		11,200	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		16,427,177	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		16,427,177	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		19,006,772	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		19,006,772	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.864280	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,036.64	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)		16,427,177	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)		752.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,429,232	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)		8,429,232	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 11/14/2012 4:15 pm	
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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT	2,360,949	1,658	1,423.97	1,017	1,448,177		44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					12,385,171		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,262,580		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					529,086		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					890,992		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,420,078		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,842,502		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					3,492		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					752.61		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,628,114		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/14/2012 4:15 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	874,555	16,427,177	0.053238	2,628,114	139,916	90.00
91.00	Nursing School cost	0	16,427,177	0.000000	2,628,114	0	91.00
92.00	Allied health cost	0	16,427,177	0.000000	2,628,114	0	92.00
93.00	All other Medical Education	0	16,427,177	0.000000	2,628,114	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1
		Component CCN: 14S189		Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,846	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,846	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,846	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,379	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,874,692	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,874,692	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,048,231	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,048,231	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.710111	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,052.58	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)		2,874,692	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)		747.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,030,734	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)		1,030,734	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
		Component CCN: 14S189				Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0		44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					278,915		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,309,649		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					49,851		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,893		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					60,744		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,248,905		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140189 Component CCN: 14S189		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	139,043	2,874,692	0.048368	0	0	90.00
91.00	Nursing School cost	0	2,874,692	0.000000	0	0	91.00
92.00	Allied health cost	0	2,874,692	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,874,692	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/14/2012 4:15 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		11,268,516	30.00
32.00	03200	CORONARY CARE UNIT		1,643,565	32.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.354953	4,706,469	50.00
51.00	05100	RECOVERY ROOM	0.309637	530,184	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307153	7,993	52.00
53.00	05300	ANESTHESIOLOGY	0.278447	1,118,234	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286831	2,347,950	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.294739	87,740	55.00
56.00	05600	RADIOISOTOPE	0.187738	1,442,440	56.00
57.00	05700	CT SCAN	0.060134	4,437,787	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.097696	587,148	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.446123	226,362	59.00
60.00	06000	LABORATORY	0.225706	7,054,788	60.00
65.00	06500	RESPIRATORY THERAPY	0.210996	3,563,813	65.00
66.00	06600	PHYSICAL THERAPY	0.401092	430,194	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.629941	117,477	67.00
68.00	06800	SPEECH PATHOLOGY	0.076149	75,621	68.00
69.00	06900	ELECTROCARDIOLOGY	0.445321	562,775	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174959	15,500	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260982	3,457,150	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.405725	5,238,311	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232432	11,226,572	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.180110	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.525880	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100	EMERGENCY	0.208982	1,695,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.580299	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		48,930,319	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		48,930,319	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3	
		Component CCN: 14S189		Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
32.00	03200	CORONARY CARE UNIT		0	32.00
40.00	04000	SUBPROVIDER - IPF		1,439,388	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.354953	4,289	50.00
51.00	05100	RECOVERY ROOM	0.309637	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307153	0	52.00
53.00	05300	ANESTHESIOLOGY	0.278447	852	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286831	10,840	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.294739	0	55.00
56.00	05600	RADIOISOTOPE	0.187738	7,097	56.00
57.00	05700	CT SCAN	0.060134	48,726	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.097696	12,560	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.446123	0	59.00
60.00	06000	LABORATORY	0.225706	317,502	60.00
65.00	06500	RESPIRATORY THERAPY	0.210996	89,162	65.00
66.00	06600	PHYSICAL THERAPY	0.401092	2,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.629941	1,464	67.00
68.00	06800	SPEECH PATHOLOGY	0.076149	136	68.00
69.00	06900	ELECTROCARDIOLOGY	0.445321	8,837	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.174959	4,157	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.260982	9,665	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.405725	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232432	509,172	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.180110	0	75.00
76.00	03020	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.525880	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100	EMERGENCY	0.208982	241,975	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.580299	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,269,054	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,269,054	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part A Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		17,188,342	1.00
2.00	Outlier payments for discharges. (see instructions)		226,089	2.00
2.01	For inpatient PPS services rendered during the cost reporting period enter the operating outlier reconciliation amount for operating expenses from line 92.		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		79.46	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.75	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		14.75	31.00
32.00	Sum of lines 30 and 31		18.50	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.02	33.00
34.00	Disproportionate share adjustment (see instructions)		862,855	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		18,277,286	47.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part A Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
			1.00	1.01	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		20,871,156		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		20,871,156		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,387,399		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		22,258,555		59.00
60.00	Primary payer payments		2,835		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,255,720		61.00
62.00	Deductibles billed to program beneficiaries		2,363,164		62.00
63.00	Coinurance billed to program beneficiaries		51,438		63.00
64.00	Allowable bad debts (see instructions)		544,227		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		380,959		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		544,227		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		20,222,077		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95 and 96. For SCH, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1		0		70.96
70.97	Low Volume Payment-2		0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,222,077		71.00
72.00	Interim payments		19,891,310		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)		330,767		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,365	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,450,245	2.00
3.00	PPS payments		15,419,473	3.00
4.00	Outlier payment (see instructions)		38,154	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.917	5.00
6.00	Line 2 times line 5		16,001,875	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		96.60	7.00
8.00	Transitional corridor payment (see instructions)		462,611	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)		7,365	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		30,440	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)		30,440	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)		30,440	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		23,075	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)		7,365	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)		15,920,238	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,675,194	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)		12,252,409	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)		12,252,409	30.00
31.00	Primary payer payments		362	31.00
32.00	Subtotal (line 30 minus line 31)		12,252,047	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)		811,597	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		568,118	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		811,597	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		12,820,165	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-14	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)		12,820,179	40.00
41.00	Interim payments		13,226,957	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)		-406,778	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/14/2012 4:15 pm
	Title XVIII	Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
11/14/2012 4:15 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		19,729,818		13,228,979	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	03/02/2012	161,492		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	03/02/2012	2,022	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)		161,492		-2,022	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)		19,891,310		13,226,957	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		330,767		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		406,778	6.02	
7.00	Total Medicare program liability (see instructions)		20,222,077		12,820,179	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140189
Component CCN: 14S189

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
11/14/2012 4:15 pm
PPS

Title XVIII

Subprovider -
IPF

		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		934,242		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		934,242		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		75,790		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,010,032		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part II Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,123,610 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			10.508197 9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,123,610 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition			0 14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,123,610 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,123,610 18.00
19.00	Deductibles			187,658 19.00
20.00	Subtotal (line 18 minus line 19)			935,952 20.00
21.00	Coinurance			1,710 21.00
22.00	Subtotal (line 20 minus line 21)			934,242 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			108,271 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			75,790 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			108,271 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,010,032 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,010,032 31.00
32.00	Interim payments			934,242 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)			75,790 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet G
Date/Time Prepared:
11/14/2012 4:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	24,863,614	0	0	0	1.00
2.00	Temporary investments	15,137,398	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	65,853,331	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-34,702,569	0	0	0	6.00
7.00	Inventory	3,131,064	0	0	0	7.00
8.00	Prepaid expenses	5,089,224	0	0	0	8.00
9.00	Other current assets	3,638,733	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)	83,010,795	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,194,269	0	0	0	12.00
13.00	Land improvements	7,097,949	0	0	0	13.00
14.00	Accumulated depreciation	-3,420,208	0	0	0	14.00
15.00	Buildings	92,474,510	0	0	0	15.00
16.00	Accumulated depreciation	-37,950,822	0	0	0	16.00
17.00	Leasehold improvements	169,555	0	0	0	17.00
18.00	Accumulated depreciation	-70,265	0	0	0	18.00
19.00	Fixed equipment	13,601,379	0	0	0	19.00
20.00	Accumulated depreciation	-10,730,865	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	71,625,932	0	0	0	23.00
24.00	Accumulated depreciation	-54,968,893	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	81,022,541	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	74,377,648	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	76,953,019	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	151,330,667	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	315,364,003	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,099,603	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,103,601	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,664,926	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,433,419	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	35,301,549	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	81,902,510	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	81,902,510	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	117,204,059	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	198,159,944				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)	198,159,944	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	315,364,003	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-1

Date/Time Prepared:
11/14/2012 4:15 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		181,633,301	
2.00	Net income (loss) (From Wkst. G-3, line 29)		16,526,643			2.00
3.00	Total (sum of line 1 and line 2)		198,159,944		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)		198,159,944		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)		198,159,944		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-2 Parts
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,006,772		19,006,772	1.00
2.00	SUBPROVIDER - IPF	4,048,231		4,048,231	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	23,055,003		23,055,003	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT	2,754,391		2,754,391	12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,754,391		2,754,391	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,809,394		25,809,394	17.00
18.00	Ancillary services	96,640,506	232,651,507	329,292,013	18.00
19.00	Outpatient services	0	34,621,530	34,621,530	19.00
20.00	RURAL HEALTH CLINIC	0	433,249	433,249	20.00
20.01	RURAL HEALTH CLINIC II	0	419,813	419,813	20.01
20.02	RURAL HEALTH CLINIC III	0	775,481	775,481	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,331,320	5,331,320	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	5,747,049	5,747,049	26.00
27.00	NURSERY (INPATIENT REVENUES)	1,375,523	0	1,375,523	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	123,825,423	279,979,949	403,805,372	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		182,540,375		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		182,540,375		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-3

Date/Time Prepared:
11/14/2012 4:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	403,805,372	1.00
2.00	Less contractual allowances and discounts on patients' accounts	245,949,508	2.00
3.00	Net patient revenues (line 1 minus line 2)	157,855,864	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	182,540,375	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-24,684,511	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	660,411	6.00
7.00	Income from investments	797,473	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	158,551	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	638,639	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	94,582	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	23,801	21.00
22.00	Rental of hospital space	360,549	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHYSICIAN PRACTICE, GRANTS, MISC.	38,477,148	24.00
25.00	Total other income (sum of lines 6-24)	41,211,154	25.00
26.00	Total (line 5 plus line 25)	16,526,643	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,526,643	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet H

HHA CCN: 147594

To 06/30/2012

Date/Time Prepared: 11/14/2012 4:15 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures		0		0	1.00
2.00	Capital Related - Movable Equipment		0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	725,464	194,769	120,664	217,868	162,540
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	1,297,633	0	0	0	6.00
7.00	Physical Therapy	398,648	0	0	0	7.00
8.00	Occupational Therapy	117,814	0	0	0	8.00
9.00	Speech Pathology	57,780	0	0	0	9.00
10.00	Medical Social Services	45,671	0	0	0	10.00
11.00	Home Health Aide	97,005	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,740,015	194,769	120,664	217,868	162,540

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet H

HHA CCN: 147594

To 06/30/2012

Date/Time Prepared: 11/14/2012 4:15 pm

Home Health Agency I

PPS

	Total (sum of col.s. 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	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	1,421,305	0	1,421,305	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	1,297,633	0	1,297,633	0	6.00
7.00	Physical Therapy	398,648	0	398,648	0	7.00
8.00	Occupational Therapy	117,814	0	117,814	0	8.00
9.00	Speech Pathology	57,780	0	57,780	0	9.00
10.00	Medical Social Services	45,671	0	45,671	0	10.00
11.00	Home Health Aide	97,005	0	97,005	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,435,856	0	3,435,856	0	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140189 HHA CCN: 147594	Period: From 07/01/2011 To 06/30/2012	Worksheet H-1 Part I Date/Time Prepared: 11/14/2012 4:15 pm PPS
		Home Health Agency I		

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	1,421,305	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	1,297,633	0	0	0	6.00
7.00	Physical Therapy	398,648	0	0	0	7.00
8.00	Occupational Therapy	117,814	0	0	0	8.00
9.00	Speech Pathology	57,780	0	0	0	9.00
10.00	Medical Social Services	45,671	0	0	0	10.00
11.00	Home Health Aide	97,005	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,435,856	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140189	Period: From 07/01/2011	Worksheet H-1 Part I Date/Time Prepared: 11/14/2012 4:15 pm
		HHA CCN: 147594	To 06/30/2012	
			Home Health Agency I	PPS

		Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)	
		4A.00	5.00	6.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0			1.00
2.00	Capital Related - Movable Equipment	0			2.00
3.00	Plant Operation & Maintenance	0			3.00
4.00	Transportation				4.00
5.00	Administrative and General	1,421,305	1,421,305		5.00
HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	1,297,633	915,505	2,213,138	6.00
7.00	Physical Therapy	398,648	281,254	679,902	7.00
8.00	Occupational Therapy	117,814	83,120	200,934	8.00
9.00	Speech Pathology	57,780	40,765	98,545	9.00
10.00	Medical Social Services	45,671	32,222	77,893	10.00
11.00	Home Health Aide	97,005	68,439	165,444	11.00
12.00	Supplies (see instructions)	0	0	0	12.00
13.00	Drugs	0	0	0	13.00
14.00	DME	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	17.00
18.00	Clinic	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	19.00
20.00	Day Care Program	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	21.00
22.00	Homemaker Service	0	0	0	22.00
23.00	All Others (specify)	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,014,551		3,435,856	24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 140189 HHA CCN: 147594		Period: From 07/01/2011 To 06/30/2012		Worksheet H-1 Part II Date/Time Prepared: 11/14/2012 4:15 pm PPS	
		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-1,421,305	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-1,421,305	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 140189	Period: From 07/01/2011	Worksheet H-1 Part II Date/Time Prepared: 11/14/2012 4:15 pm
	HHA CCN: 147594	To 06/30/2012	
		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	2,014,551	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	1,297,633	6.00
7.00	Physical Therapy	398,648	7.00
8.00	Occupational Therapy	117,814	8.00
9.00	Speech Pathology	57,780	9.00
10.00	Medical Social Services	45,671	10.00
11.00	Home Health Aide	97,005	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	2,014,551	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	1,421,305	25.00
26.00	Unit Cost Multiplier	0.705519	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140189
HHA CCN: 147594

Period:
From 07/01/2011
To 06/30/2012

Worksheet H-2
Part I
Date/Time Prepared:
11/14/2012 4:15 pm
PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General	0	24,787	4,450	559,155	588,392	1.00
2.00 Skilled Nursing Care	2,213,138	0	0	0	2,213,138	2.00
3.00 Physical Therapy	679,902	0	0	0	679,902	3.00
4.00 Occupational Therapy	200,934	0	0	0	200,934	4.00
5.00 Speech Pathology	98,545	0	0	0	98,545	5.00
6.00 Medical Social Services	77,893	0	0	0	77,893	6.00
7.00 Home Health Aide	165,444	0	0	0	165,444	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	3,435,856	24,787	4,450	559,155	4,024,248	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140189

Period:

Worksheet H-2

HHA CCN: 147594

From 07/01/2011
To 06/30/2012

Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Home Health
Agency I

PPS

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	137,791	54,706	0	16,546	0	1.00
2.00	Skilled Nursing Care	518,277	0	0	0	0	2.00
3.00	Physical Therapy	159,221	0	0	0	0	3.00
4.00	Occupational Therapy	47,055	0	0	0	0	4.00
5.00	Speech Pathology	23,077	0	0	0	0	5.00
6.00	Medical Social Services	18,241	0	0	0	0	6.00
7.00	Home Health Aide	38,744	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	942,406	54,706	0	16,546	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140189
HHA CCN: 147594

Period:
From 07/01/2011
To 06/30/2012

Worksheet H-2
Part I
Date/Time Prepared:
11/14/2012 4:15 pm
PPS

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	35,047	0	0	0	39,660	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	35,047	0	0	0	39,660	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet H-2

HHA CCN: 147594

To 06/30/2012

Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Home Health Agency I

PPS

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	872,142	0	872,142			1.00
2.00	Skilled Nursing Care	2,731,415	0	2,731,415	561,773	3,293,188	2.00
3.00	Physical Therapy	839,123	0	839,123	172,583	1,011,706	3.00
4.00	Occupational Therapy	247,989	0	247,989	51,004	298,993	4.00
5.00	Speech Pathology	121,622	0	121,622	25,014	146,636	5.00
6.00	Medical Social Services	96,134	0	96,134	19,772	115,906	6.00
7.00	Home Health Aide	204,188	0	204,188	41,996	246,184	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	5,112,613	0	5,112,613	872,142	5,112,613	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.				0.205671		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140189
HHA CCN: 147594

Period:
From 07/01/2011
To 06/30/2012

Worksheet H-2
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

Home Health Agency I

PPS

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
1.00 Administrative and General	3,990	3,621	2,740,015	5A	588,392	1.00	
2.00 Skilled Nursing Care	0	0	0		2,213,138	2.00	
3.00 Physical Therapy	0	0	0		679,902	3.00	
4.00 Occupational Therapy	0	0	0		200,934	4.00	
5.00 Speech Pathology	0	0	0		98,545	5.00	
6.00 Medical Social Services	0	0	0		77,893	6.00	
7.00 Home Health Aide	0	0	0		165,444	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 (specify)	0	0	0		0	19.00	
20.00 Total (sum of lines 1-19)	3,990	3,621	2,740,015		4,024,248	20.00	
21.00 Total cost to be allocated	24,787	4,450	559,155		942,406	21.00	
22.00 Unit cost multiplier	6.212281	1.228942	0.204070		0.234182	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140189
HHA CCN: 147594

Period:
From 07/01/2011
To 06/30/2012

Worksheet H-2
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

Home Health Agency I

PPS

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	3,276	0	47	0	29	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	3,276	0	47	0	29	20.00
21.00	Total cost to be allocated	54,706	0	16,546	0	35,047	21.00
22.00	Unit cost multiplier	16.699023	0.000000	352.042553	0.000000	1,208.517241	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet H-2 Part II
	HHA CCN: 147594		Date/Time Prepared: 11/14/2012 4:15 pm
		Home Health Agency I	PPS

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	(DIRECT NRSING HRS)	(COSTED REQUIS.)				
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	0	0	5,331,320		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 (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	0	0	0	5,331,320		20.00
21.00 Total cost to be allocated	0	0	0	39,660		21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.007439		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140189 HHA CCN: 147594		Period: From 07/01/2011 To 06/30/2012		Worksheet H-3 Parts I-III Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	3,293,188		3,293,188	18,581	1.00
2.00	Physical Therapy	3.00	1,011,706	0	1,011,706	5,685	2.00
3.00	Occupational Therapy	4.00	298,993	0	298,993	1,800	3.00
4.00	Speech Pathology	5.00	146,636	0	146,636	516	4.00
5.00	Medical Social Services	6.00	115,906		115,906	336	5.00
6.00	Home Health Aide	7.00	246,184		246,184	3,565	6.00
7.00	Total (sum of lines 1-6)		5,112,613	0	5,112,613	30,483	7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits		
					Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	6,941	5,901		8.00
9.00	Physical Therapy		99914	2,740	1,461		9.00
10.00	Occupational Therapy		99914	916	430		10.00
11.00	Speech Pathology		99914	233	181		11.00
12.00	Medical Social Services		99914	125	117		12.00
13.00	Home Health Aide		99914	1,075	2,063		13.00
14.00	Total (sum of lines 8-13)			12,030	10,153		14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
Cost Center Description		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)		
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.401092	0	0	1.00
2.00	Occupational Therapy		67.00	0.629941	0	0	2.00
3.00	Speech Pathology		68.00	0.076149	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.260982	0	0	4.00
5.00	Cost of Drugs		73.00	0.232432	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140189
HHA CCN: 147594

Period:
From 07/01/2011
To 06/30/2012

Worksheet H-3
Parts I-III
Date/Time Prepared:
11/14/2012 4:15 pm
PPS

Title XVIII

Home Health Agency I

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	177.23	6,941	5,901		1.00
2.00	Physical Therapy	177.96	2,740	1,461		2.00
3.00	Occupational Therapy	166.11	916	430		3.00
4.00	Speech Pathology	284.18	233	181		4.00
5.00	Medical Social Services	344.96	125	117		5.00
6.00	Home Health Aide	69.06	1,075	2,063		6.00
7.00	Total (sum of lines 1-6)		12,030	10,153		7.00
Cost Center Description						
		5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
Program Covered Charges						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000				15.00
16.00	Cost of Drugs	0.000000		0	0	16.00
Cost Center Description						
			Transfer to Part I as Indicated			
			4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	col. 2, line 2.00				1.00
2.00	Occupational Therapy	col. 2, line 3.00				2.00
3.00	Speech Pathology	col. 2, line 4.00				3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00				4.00
5.00	Cost of Drugs	col. 2, line 16.00				5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140189 HHA CCN: 147594		Period: From 07/01/2011 To 06/30/2012		Worksheet H-3 Parts I-III Date/Time Prepared: 11/14/2012 4:15 pm PPS	
		Title XVIII		Home Health Agency I			
Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)			
	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
9.00	10.00	11.00	12.00				
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,230,153	1,045,834		2,275,987		1.00
2.00	Physical Therapy	487,610	260,000		747,610		2.00
3.00	Occupational Therapy	152,157	71,427		223,584		3.00
4.00	Speech Pathology	66,214	51,437		117,651		4.00
5.00	Medical Social Services	43,120	40,360		83,480		5.00
6.00	Home Health Aide	74,240	142,471		216,711		6.00
7.00	Total (sum of lines 1-6)	2,053,494	1,611,529		3,665,023		7.00
Cost Center Description							
		10.00	11.00	12.00			
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
Cost of Services							
Cost Center Description	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
	9.00	10.00	11.00				
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies						15.00
16.00	Cost of Drugs		0	0			16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140189 HHA CCN: 147594	Period: From 07/01/2011 To 06/30/2012	Worksheet H-4 Part I-II Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		1,727,932	1,350,783
12.00	Total PPS Reimbursement - Full Episodes with Outliers		17,025	14,595
13.00	Total PPS Reimbursement - LUPA Episodes		18,953	26,364
14.00	Total PPS Reimbursement - PEP Episodes		18,027	7,774
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		2,973	3,771
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		1,784,910	1,403,287
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		1,784,910	1,403,287
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		1,784,910	1,403,287
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		1,784,910	1,403,287
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		1,784,910	1,403,287
32.00	Interim payments (see instructions)		1,784,910	1,403,286
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140189
HHA CCN: 147594

Period:
From 07/01/2011
To 06/30/2012

Worksheet H-5
Date/Time Prepared:
11/14/2012 4:15 pm
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,784,910		1,403,286	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		1,784,910		1,403,286	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		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,784,910		1,403,287	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K

Hospice CCN: 141599

To 06/30/2012

Date/Time Prepared: 11/14/2012 4:15 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	154,668	0	0	0	709,165	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	1,008,534	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	3,812	0	0	0	0	12.00
13.00	Occupational Therapy	539	0	0	0	0	13.00
14.00	Speech/ Language Pathology	96	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,167,649	0	0	0	709,165	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K

Hospice CCN: 141599

To 06/30/2012

Date/Time Prepared: 11/14/2012 4:15 pm

		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	863,833	0	863,833	0	863,833	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	1,008,534	0	1,008,534	0	1,008,534	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	3,812	0	3,812	0	3,812	12.00
13.00	Occupational Therapy	539	0	539	0	539	13.00
14.00	Speech/ Language Pathology	96	0	96	0	96	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,876,814	0	1,876,814	0	1,876,814	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K-1

Hospice CCN: 141599

To 06/30/2012

Date/Time Prepared: 11/14/2012 4:15 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	89,160	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	149,499	0	728,623	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	89,160	149,499	0	728,623	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K-1

Hospice CCN: 141599

To 06/30/2012

Date/Time Prepared: 11/14/2012 4:15 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	65,508	154,668	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		130,412	0	1,008,534	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	3,812	0	0	3,812	12.00
13.00	Occupational Therapy	539	0	0	539	13.00
14.00	Speech/ Language Pathology	96	0	0	96	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	4,447	130,412	65,508	1,167,649	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189
 Hospice CCN: 141599

Period:
 From 07/01/2011
 To 06/30/2012

Worksheet K-4
 Part I
 Date/Time Prepared:
 11/14/2012 4:15 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	863,833	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	1,008,534	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	3,812	0	0	0	0	12.00
13.00	Occupational Therapy	539	0	0	0	0	13.00
14.00	Speech/ Language Pathology	96	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,876,814	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K-4

Hospice CCN: 141599

To 06/30/2012

Part I
Date/Time Prepared:
11/14/2012 4:15 pm

		Hospice I				
		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	863,833	863,833		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	1,008,534	860,040	1,868,574	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	3,812	3,251	7,063	12.00
13.00	Occupational Therapy	0	539	460	999	13.00
14.00	Speech/ Language Pathology	0	96	82	178	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	1,876,814		1,876,814	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K-4

Hospice CCN: 141599

To 06/30/2012

Part II
Date/Time Prepared:
11/14/2012 4:15 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140189
Hospice CCN: 141599

Period:
From 07/01/2011
To 06/30/2012

Worksheet K-4
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-863,833	1,012,981	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	1,008,534	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	3,812	12.00
13.00	Occupational Therapy	0	539	13.00
14.00	Speech/ Language Pathology	0	96	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		863,833	39.00
40.00	Unit Cost Multiplier		0.852763	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K-5

Hospice CCN: 141599

To 06/30/2012

Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General		9,319	515	238,282	248,116	1.00
2.00 Inpatient - General Care	1,868,574	0	0	0	1,868,574	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	7,063	0	0	0	7,063	7.00
8.00 Occupational Therapy	999	0	0	0	999	8.00
9.00 Speech/ Language Pathology	178	0	0	0	178	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	1,876,814	9,319	515	238,282	2,124,930	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period:

Worksheet K-5

Hospice CCN: 141599

From 07/01/2011
To 06/30/2012

Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	58,104	39,076	0	7,745	0	1.00
2.00	Inpatient - General Care	437,586	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	1,654	0	0	0	0	7.00
8.00	Occupational Therapy	234	0	0	0	0	8.00
9.00	Speech/ Language Pathology	42	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specif y	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	497,620	39,076	0	7,745	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K-5

Hospice CCN: 141599

To 06/30/2012

Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description	Hospice I					
	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	4,834	0	0	0	42,752	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	4,834	0	0	0	42,752	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K-5

Hospice CCN: 141599

To 06/30/2012

Part I
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Hospice I					
		Subtotal (col.s. 4A-23) 24.00	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Subtotal (col.s. 24 ± 25) 26.00	Allocated Hospice A&G (See Part II) 27.00	Total Hospice Costs (col.s. 26 ± 27) 28.00	
1.00	Administrative and General	400,627					1.00
2.00	Inpatient - General Care	2,306,160	0	2,306,160	398,868	2,705,028	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	8,717	0	8,717	1,508	10,225	7.00
8.00	Occupational Therapy	1,233	0	1,233	213	1,446	8.00
9.00	Speech/ Language Pathology	220	0	220	38	258	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specif y	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2,716,957	0	2,716,957		2,716,957	34.00
35.00	Unit Cost Multiplier (see instructions)				0.172958		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189
Hospice CCN: 141599

Period:
From 07/01/2011
To 06/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
1.00	Administrative and General	9,165	515	238,276	0	248,116	1.00
2.00	Inpatient - General Care	0	0	0	0	1,868,574	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	7,063	7.00
8.00	Occupational Therapy	0	0	0	0	999	8.00
9.00	Speech/ Language Pathology	0	0	0	0	178	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	9,165	515	238,276		2,124,930	34.00
35.00	Total cost to be allocated	9,319	515	238,282		497,620	35.00
36.00	Unit Cost Multiplier (see instructions)	1.016803	1.000000	1.000025		0.234182	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189

Period:
From 07/01/2011
To 06/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	39,022	0	7,736	0	4,828	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	39,022	0	7,736	0	4,828	34.00
35.00	Total cost to be allocated	39,076	0	7,745	0	4,834	35.00
36.00	Unit Cost Multiplier (see instructions)	1.001384	0.000000	1.001163	0.000000	1.001243	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189
Hospice CCN: 141599

Period:
From 07/01/2011
To 06/30/2012

Worksheet K-5
Part II
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Hospice I					
		NURSING ADMINISTRATION (DIRECT NURSING HRS) 13.00	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14.00	PHARMACY (COSTED REQUIS.) 15.00	MEDICAL RECORDS & LIBRARY (GROSS CHARGES) 16.00		
1.00	Administrative and General	0	0	0	42,817		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	42,817		34.00
35.00	Total cost to be allocated	0	0	0	42,752		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.998482		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K-5

Hospice CCN: 141599

To 06/30/2012

Part III
Date/Time Prepared:
11/14/2012 4:15 pm

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.401092	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.629941	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.076149	0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.232432	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.225706	0	0 6.00
6.01	BLOOD LABORATORY	60.01			6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.260982	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.294739	0	0 9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	3.525880	0	0 10.00
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140189

Period: From 07/01/2011

Worksheet K-6

Hospice CCN: 141599

To 06/30/2012

Date/Time Prepared: 11/14/2012 4:15 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				2,716,957	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				21,180	2.00
3.00	Average cost per diem (line 1 divided by line 2)				128.28	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	18,760				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	2,406,533				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		827			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		106,088			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	9,304				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	1,193,517				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		162			10.00
11.00	Aggregate NF cost (line 3 times line 10)		20,781			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			1,593		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			204,350		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet L Parts I-III Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,370,816	1.00
2.00	Capital DRG outlier payments		16,583	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		54.63	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,387,399	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1 Date/Time Prepared: 11/14/2012 4:15 pm
----------------------------------------------------------------------------------------	-----------------------------------------------	---------------------------------------------	------------------------------------------------------------

		Title XVIII		Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	102,951	6,674	109,625	0	109,625
3.00	Nurse Practitioner	31,509	5,364	36,873	0	36,873
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	108,003	7,407	115,410	0	115,410
10.00	Subtotal (sum of lines 1-9)	242,463	19,445	261,908	0	261,908
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0
15.00	Medical Supplies	0	16,216	16,216	0	16,216
16.00	Transportation (Health Care Staff)	0	3,092	3,092	0	3,092
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	16,334	16,334	0	16,334
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15-20)	0	35,642	35,642	0	35,642
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	242,463	55,087	297,550	0	297,550
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	54,307	54,307	0	54,307
30.00	Administrative Costs	51,082	5,019	56,101	0	56,101
31.00	Total Facility Overhead (sum of lines 29 and 30)	51,082	59,326	110,408	0	110,408
32.00	Total facility costs (sum of lines 22, 28 and 31)	293,545	114,413	407,958	0	407,958

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1
	Component CCN: 143978		Date/Time Prepared: 11/14/2012 4:15 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	109,625
3.00	Nurse Practitioner	0	36,873
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	115,410
10.00	Subtotal (sum of lines 1-9)	0	261,908
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	0
15.00	Medical Supplies	0	16,216
16.00	Transportation (Health Care Staff)	0	3,092
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	16,334
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	35,642
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	297,550
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	54,307
30.00	Administrative Costs	0	56,101
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	110,408
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	407,958

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS		Provider CCN: 140189 Component CCN: 143998		Period: From 07/01/2011 To 06/30/2012		Worksheet M-1 Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII		Rural Health Clinic (RHC) II		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	222,786	15,890	238,676	0	238,676	1.00
2.00	Physician Assistant	90,379	8,877	99,256	0	99,256	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	85,087	5,904	90,991	0	90,991	9.00
10.00	Subtotal (sum of lines 1-9)	398,252	30,671	428,923	0	428,923	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	19,646	19,646	0	19,646	15.00
16.00	Transportation (Health Care Staff)	0	970	970	0	970	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	21,098	21,098	0	21,098	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	41,714	41,714	0	41,714	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	398,252	72,385	470,637	0	470,637	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	54,774	54,774	0	54,774	29.00
30.00	Administrative Costs	62,902	8,603	71,505	0	71,505	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	62,902	63,377	126,279	0	126,279	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	461,154	135,762	596,916	0	596,916	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1
	Component CCN: 143998	Date/Time Prepared: 11/14/2012 4:15 pm	
Title XVIII		Rural Health Clinic (RHC) II	Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	238,676	1.00
2.00	Physician Assistant	0	99,256	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	90,991	9.00
10.00	Subtotal (sum of lines 1-9)	0	428,923	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	19,646	15.00
16.00	Transportation (Health Care Staff)	0	970	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	21,098	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	41,714	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	470,637	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	54,774	29.00
30.00	Administrative Costs	0	71,505	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	126,279	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	596,916	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS		Provider CCN: 140189 Component CCN: 143435		Period: From 07/01/2011 To 06/30/2012		Worksheet M-1 Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII		Rural Health Clinic (RHC) III		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	218,826	20,019	238,845	0	238,845	1.00
2.00	Physician Assistant	274,485	10,001	284,486	0	284,486	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	76,064	5,080	81,144	0	81,144	9.00
10.00	Subtotal (sum of lines 1-9)	569,375	35,100	604,475	0	604,475	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	21,393	21,393	0	21,393	15.00
16.00	Transportation (Health Care Staff)	0	968	968	0	968	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	28,390	28,390	0	28,390	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	50,751	50,751	0	50,751	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	569,375	85,851	655,226	0	655,226	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	42,371	42,371	0	42,371	29.00
30.00	Administrative Costs	89,175	11,084	100,259	0	100,259	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	89,175	53,455	142,630	0	142,630	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	658,550	139,306	797,856	0	797,856	32.00

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

Provider CCN: 140189
Component CCN: 143435

Period:
From 07/01/2011
To 06/30/2012

Worksheet M-1
Date/Time Prepared:
11/14/2012 4:15 pm
Cost

Title XVIII

Rural Health
Clinic (RHC) III

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	238,845	1.00
2.00	Physician Assistant	0	284,486	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	81,144	9.00
10.00	Subtotal (sum of lines 1-9)	0	604,475	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	21,393	15.00
16.00	Transportation (Health Care Staff)	0	968	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	28,390	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	50,751	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	655,226	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	42,371	29.00
30.00	Administrative Costs	0	100,259	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	142,630	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	797,856	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2011	Worksheet M-2		
		Component CCN: 143978	To 06/30/2012	Date/Time Prepared: 11/14/2012 4:15 pm		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	0	0	1.00
2.00	Physician Assistant	0.70	3,614	2,100	1,470	2.00
3.00	Nurse Practitioner	0.36	247	2,100	756	3.00
4.00	Subtotal (sum of lines 1-3)	1.06	3,861		2,226	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.06	3,861			8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				297,550	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				297,550	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				110,408	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				533,768	15.00
16.00	Total overhead (sum of lines 14 and 15)				644,176	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				644,176	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				644,176	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				941,726	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2011	Worksheet M-2		
		Component CCN: 143998	To 06/30/2012	Date/Time Prepared: 11/14/2012 4:15 pm		
		Title XVIII	Rural Health Clinic (RHC) II	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.01	1,670	2,100	2,121	1.00
2.00	Physician Assistant	1.01	1,465	2,100	2,121	2.00
3.00	Nurse Practitioner	0.00	0	0	0	3.00
4.00	Subtotal (sum of lines 1-3)	2.02	3,135		4,242	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.02	3,135		4,242	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				470,637	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				470,637	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				126,279	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				430,452	15.00
16.00	Total overhead (sum of lines 14 and 15)				556,731	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				556,731	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				556,731	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,027,368	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet M-2		
		Component CCN: 143435		Date/Time Prepared: 11/14/2012 4:15 pm		
		Title XVIII	Rural Health Clinic (RHC) III	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.85	1,046	2,100	1,785	1.00
2.00	Physician Assistant	1.29	4,846	2,100	2,709	2.00
3.00	Nurse Practitioner	0.00	0	0	0	3.00
4.00	Subtotal (sum of lines 1-3)	2.14	5,892		4,494	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.14	5,892			8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				655,226	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				655,226	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				142,630	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				430,063	15.00
16.00	Total overhead (sum of lines 14 and 15)				572,693	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				572,693	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				572,693	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,227,919	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3
		Component CCN: 143978		Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		941,726	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		9,979	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		931,747	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,861	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,861	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		241.32	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)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	78.07	78.54	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	371	425	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	28,964	33,380	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) *	28,964	33,380	16.00
16.01	Total program charges (see instructions)(from contractor's records)		93,565	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		148	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		99	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		37,727	16.04
16.05	Total program cost (see instructions)		37,826	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,086	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		37,826	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,112	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		38,938	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		38,938	26.00
27.00	Interim payments		37,312	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		1,626	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3
		Component CCN: 143998		Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVIIII	Rural Health Clinic (RHC) II	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,027,368	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		9,293	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,018,075	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,242	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,242	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		240.00	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)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	78.07	78.54	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	269	295	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	21,001	23,169	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) *	21,001	23,169	16.00
16.01	Total program charges (see instructions)(from contractor's records)		76,441	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		472	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		273	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		27,597	16.04
16.05	Total program cost (see instructions)		27,870	16.05
17.00	Primary payer amounts		167	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		9,401	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		27,703	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		278	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		27,981	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		27,981	26.00
27.00	Interim payments		27,109	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)		872	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3
		Component CCN: 143435		Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVIII	Rural Health Clinic (RHC) III	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,227,919	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		6,753	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,221,166	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,892	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,892	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		207.26	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)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	78.07	78.54	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	472	664	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	36,849	52,151	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) *	36,849	52,151	16.00
16.01	Total program charges (see instructions)(from contractor's records)		163,144	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		59,286	16.04
16.05	Total program cost (see instructions)		59,286	16.05
17.00	Primary payer amounts		51	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,892	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		59,235	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		136	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		59,371	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		59,371	26.00
27.00	Interim payments		58,382	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)		989	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140189
Component CCN: 143978

Period:
From 07/01/2011
To 06/30/2012

Worksheet M-4
Date/Time Prepared:
11/14/2012 4:15 pm
Cost

Title XVIII

Rural Health
Clinic (RHC) I

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	261,908	261,908	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	715	2,438	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	715	2,438	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	297,550	297,550	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	644,176	644,176	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002403	0.008194	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,548	5,278	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,263	7,716	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	13	202	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	174.08	38.20	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	20	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	348	764	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)		9,979	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,112	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2011 To 06/30/2012	Worksheet M-4 Date/Time Prepared: 11/14/2012 4:15 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	428,923	428,923	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,650	2,607	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,650	2,607	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	470,637	470,637	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	556,731	556,731	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003506	0.005539	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,952	3,084	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,602	5,691	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	30	216	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	120.07	26.35	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	6	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	120	158	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)		9,293	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)		278	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140189
Component CCN: 143435

Period:
From 07/01/2011
To 06/30/2012

Worksheet M-4
Date/Time Prepared:
11/14/2012 4:15 pm
Cost

Title XVIII
Rural Health Clinic (RHC) III

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	604,475	604,475	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	550	3,054	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	550	3,054	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	655,226	655,226	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	572,693	572,693	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000839	0.004661	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	480	2,669	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,030	5,723	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	10	253	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	103.00	22.62	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	6	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	136	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)		6,753	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)		136	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5
	Component CCN: 143978		Date/Time Prepared: 11/14/2012 4:15 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		37,312	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		37,312	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,626	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		38,938	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5 Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII	Rural Health Clinic (RHC) II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider			27,109	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			27,109	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			872	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			27,981	7.00
			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5 Date/Time Prepared: 11/14/2012 4:15 pm	
		Title XVIII	Rural Health Clinic (RHC) III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider			58,382	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			58,382	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			989	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			59,371	7.00
			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00