

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/15/2013 10:41 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 2/15/2013 Time: 10:41 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KEWANEE HOSPITAL ( 141325 ) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-143,297	-49,376	285,283	3,204,130	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	35,994	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		-9,654		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-107,303	-59,030	285,283	3,204,130	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141325		Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/15/2013 10:38 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1051 WEST SOUTH STREET	PO Box: 747	Zip Code: 61443-		County: HENRY				1.00	
2.00	City: KEWANEE	State: IL							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	KEWANEE HOSPITAL	141325	99914	1	07/01/1966	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	KEWANEE SWING BED	14Z325	99914		03/19/2003	N	0	N	7.00
8.00	Swing Beds - NF	KEWANEE SWING BED	14Z325	99914		03/19/2003	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									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FAMILY HEALTH CLINIC	143445	99914		10/01/1998	N	0	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2011	09/30/2012		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.					N			22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0		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 unpaid	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 unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid 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	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "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.					0			35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/15/2013 10:38 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N				
		1.00				
39.00	Does this facility qualify for the Inpatient Hospital Payment Adjustment for Low Volume Hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no.					39.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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 additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? 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
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
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	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-2  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	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: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/15/2013 10:38 am		
		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost 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		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
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		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
<b>TEFRA Providers</b>						
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.				86.00	
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	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
<b>Miscellaneous Cost Reporting Information</b>						
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
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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	127,811	0		118.01
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
<b>Transplant Center Information</b>					
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
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, 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
		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	Y	Y	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141325			Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/15/2013 10:38 am		
								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	166.00
								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.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							293,347	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/15/2013 10:38 am
			Y/N	Date
			1.00	2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
			Y/N	Date
			1.00	2.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
			Y/N	Type
			1.00	2.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N	Legal Oper.
			1.00	2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/15/2013 10:38 am
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		Part A		
		Description	Y/N	Date
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	N	21.00
				1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
<b>Interest Expense</b>				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
<b>Purchased Services</b>				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
<b>Provider-Based Physicians</b>				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
				Y/N
				Date
				1.00
				2.00
<b>Home Office Costs</b>				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
				1.00
				2.00
<b>Cost Report Preparer Contact Information</b>				
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.	STEVE	THOMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	WI PFLI LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	920-662-2820	STHOMPSON@WI PFLI .COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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.	PARTNER		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: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	22	8,052	39,576.00		1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,052	39,576.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,098	2,712.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		25	9,150	42,288.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
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: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,115	211	1,649		1.00
2.00 HMO		96	0			2.00
3.00 HMO IPF Subprovider		0	0			3.00
4.00 HMO IRF Subprovider		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	301	0	309		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	29		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,416	211	1,987		7.00
8.00 INTENSIVE CARE UNIT	0	76	1	113		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		0	0		13.00
14.00 Total (see instructions)	0	1,492	212	2,100		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	1,219	4,864	11,654		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	339		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				9		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	380	1.00
2.00 HMO					0	2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						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	193.20	0.00	0	380	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	16.70	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	209.90	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	84	612		1.00
2.00 HMO				2.00
3.00 HMO IPF Subprovider				3.00
4.00 HMO IRF Subprovider				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)	84	612		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/15/2013 10:38 am		
			Rural Health Clinic (RHC) I	Cost		
				1.00		
1.00	Clinic Address and Identification Street		1051 WEST SOUTH STREET	1.00		
		City	State	Zip Code		
		1.00	2.00	3.00		
2.00	City, State, Zip Code, County		KEWANEE IL 61443	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		
9.01				0 9.01		
9.02				0 9.02		
9.03				0 9.03		
9.04				0 9.04		
9.05				0 9.05		
9.06				0 9.06		
9.07				0 9.07		
9.08				0 9.08		
9.09				0 9.09		
9.10				0 9.10		
				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		09:00 19:00	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. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N 0 13.00		
			Provider name	CCN number		
			1.00	2.00		
14.00	Provider name, CCN number			14.00		
		Y/N	V	XVIII	XIX	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. Enter in column 5 the number of total visits for this provider. (see instructions)		N 0	0	0	0 15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/15/2013 10:38 am
			Rural Health Clinic (RHC) I	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	HENRY		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	09:00	17:00	09:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN: 143445		Period: From 10/01/2011 To 09/30/2012		Worksheet S-8 Date/Time Prepared: 2/15/2013 10:38 am	
				Rural Health Clinic (RHC) I		Cost	
		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
11.00	Facility hours of operations (1) Clinic	09:00	19:00	09:00	17:00	11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2011 To 09/30/2012	Worksheet S-8 Date/Time Prepared: 2/15/2013 10:38 am
			Rural Health Clinic (RHC) I	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/15/2013 10:38 am	
				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.455659	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		1,795,423	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		2,725,386	5.00	
6.00	Medicaid charges		11,028,858	6.00	
7.00	Medicaid cost (line 1 times line 6)		5,025,398	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)		504,589	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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	
<b>Uncompensated care (see instructions for each line)</b>					
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)		504,589	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,467,808	85,564	2,553,372	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,124,479	38,988	1,163,467	21.00
22.00	Partial payment by patients approved for charity care	17,155	2,068	19,223	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,107,324	36,920	1,144,244	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,638,533	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		728,996	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,909,537	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		870,098	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,014,342	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,518,931	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		3,046,328	3,046,328	19,077	3,065,405	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		1,284,819	1,284,819	0	1,284,819	2.00
4.00 00400 EMPLOYEE BENEFITS	163,166	1,714,247	1,877,413	0	1,877,413	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	1,951,599	2,564,956	4,516,555	-71,840	4,444,715	5.00
7.00 00700 OPERATION OF PLANT	274,219	637,410	911,629	0	911,629	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	119,779	119,779	0	119,779	8.00
9.00 00900 HOUSEKEEPING	215,815	47,372	263,187	0	263,187	9.00
10.00 01000 DIETARY	234,917	137,302	372,219	-253,808	118,411	10.00
11.00 01100 CAFETERIA	0	0	0	253,808	253,808	11.00
13.00 01300 NURSING ADMINISTRATION	0	108	108	0	108	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	23,791	21,097	44,888	0	44,888	14.00
15.00 01500 PHARMACY	165,673	488,010	653,683	0	653,683	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	221,761	69,180	290,941	0	290,941	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	970,846	770,641	1,741,487	57,896	1,799,383	30.00
31.00 03100 INTENSIVE CARE UNIT	103,091	32,515	135,606	1,842	137,448	31.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	450,675	517,733	968,408	121,865	1,090,273	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	380,244	25,031	405,275	0	405,275	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	737,255	1,089,201	1,826,456	-907,920	918,536	54.00
56.00 05600 RADIOISOTOPE	0	0	0	213,219	213,219	56.00
56.01 05602 ULTRASOUND	0	0	0	74,537	74,537	56.01
57.00 05700 CT SCAN	0	0	0	206,441	206,441	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	386,892	386,892	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	523,340	771,262	1,294,602	-50,239	1,244,363	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	50,239	50,239	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	218,845	218,845	65.00
66.00 06600 PHYSICAL THERAPY	493,098	42,499	535,597	0	535,597	66.00
67.00 06700 OCCUPATIONAL THERAPY	237,539	14,612	252,151	0	252,151	67.00
68.00 06800 SPEECH PATHOLOGY	130,628	9,309	139,937	0	139,937	68.00
69.01 06901 CARDIO-PULMONARY	272,981	55,088	328,069	-218,845	109,224	69.01
69.02 06902 VASCULAR LAB	0	0	0	26,831	26,831	69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,925	46,925	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 07301 ONCOLOGY	0	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	1,256,792	61,105	1,317,897	-176,337	1,141,560	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100 EMERGENCY	745,545	2,022,041	2,767,586	572	2,768,158	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 09910 CORF	0	0	0	0	0	99.10
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9,552,975	15,541,645	25,094,620	0	25,094,620	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,577	46,097	51,674	0	51,674	190.00
190.01 19001 FOUNDATION	35,557	14,203	49,760	0	49,760	190.01
190.02 19002 DURABLE MEDICAL EQUIP-RENTED	0	29,846	29,846	0	29,846	190.02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	14,453	14,453	0	14,453	192.00
200.00 TOTAL (SUM OF LINES 118-199)	9,594,109	15,646,244	25,240,353	0	25,240,353	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-386,603	2,678,802	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-387,694	897,125	2.00
4.00	00400	EMPLOYEE BENEFITS	-666	1,876,747	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-53,172	4,391,543	5.00
7.00	00700	OPERATION OF PLANT	0	911,629	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	119,779	8.00
9.00	00900	HOUSEKEEPING	0	263,187	9.00
10.00	01000	DIETARY	0	118,411	10.00
11.00	01100	CAFETERIA	-93,662	160,146	11.00
13.00	01300	NURSING ADMINISTRATION	0	108	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	44,888	14.00
15.00	01500	PHARMACY	0	653,683	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,611	289,330	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-635,647	1,163,736	30.00
31.00	03100	INTENSIVE CARE UNIT	0	137,448	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-210,178	880,095	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-380,244	25,031	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	918,536	54.00
56.00	05600	RADIO SOTOPE	0	213,219	56.00
56.01	05602	ULTRASOUND	0	74,537	56.01
57.00	05700	CT SCAN	0	206,441	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	386,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-26,602	1,217,761	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	50,239	62.00
65.00	06500	RESPIRATORY THERAPY	0	218,845	65.00
66.00	06600	PHYSICAL THERAPY	-18,976	516,621	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	252,151	67.00
68.00	06800	SPEECH PATHOLOGY	0	139,937	68.00
69.01	06901	CARDIO-PULMONARY	0	109,224	69.01
69.02	06902	VASCULAR LAB	0	26,831	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	46,925	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	ONCOLOGY	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	1,141,560	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	-1,324,859	1,443,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,519,914	21,574,706	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	51,674	190.00
190.01	19001	FOUNDATION	0	49,760	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	29,846	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,453	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,519,914	21,720,439	200.00

RECLASSIFICATIONS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6

Date/Time Prepared:  
2/15/2013 10:38 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - PROPERTY TAX EXP</b>					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	19,077	1.00
	TOTALS		0	19,077	
<b>C - CAFETERIA</b>					
1.00	CAFETERIA	11.00	161,912	91,896	1.00
	TOTALS		161,912	91,896	
<b>D - BLOOD COSTS</b>					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	5,815	44,424	1.00
	TOTALS		5,815	44,424	
<b>E - RESPIRATORY THERAPY</b>					
1.00	RESPIRATORY THERAPY	65.00	167,187	51,658	1.00
	TOTALS		167,187	51,658	
<b>G - RADIOLOGY SERVICES</b>					
1.00	RADIOISOTOPE	56.00	0	213,219	1.00
2.00	CT SCAN	57.00	80,163	126,278	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	386,892	3.00
4.00	VASCULAR LAB	69.02	0	26,831	4.00
5.00	ULTRASOUND	56.01	74,537	0	5.00
	TOTALS		154,700	753,220	
<b>H - HOSPITAL COSTS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,900	1.00
	TOTALS		0	1,900	
<b>I - CASE MANAGERS/DIRNSG</b>					
1.00	ADULTS & PEDIATRICS	30.00	52,249	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	1,842	0	2.00
3.00	EMERGENCY	91.00	572	0	3.00
	TOTALS		54,663	0	
<b>J - PROFESSIONAL SALARIES IN RHC</b>					
1.00	OPERATING ROOM	50.00	168,790	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	5,647	0	2.00
	TOTALS		174,437	0	
<b>K - IMPLANTABLE DEVICES</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	46,925	1.00
	TOTALS		0	46,925	
500.00	Grand Total: Increases		718,714	1,009,100	500.00

RECLASSIFICATIONS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6

Date/Time Prepared:  
2/15/2013 10:38 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - PROPERTY TAX EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,077	12		1.00
	TOTALS		0	19,077			
C - CAFETERIA							
1.00	DIETARY	10.00	161,912	91,896	0		1.00
	TOTALS		161,912	91,896			
D - BLOOD COSTS							
1.00	LABORATORY	60.00	5,815	44,424	0		1.00
	TOTALS		5,815	44,424			
E - RESPIRATORY THERAPY							
1.00	CARDIO-PULMONARY	69.01	167,187	51,658	0		1.00
	TOTALS		167,187	51,658			
G - RADIOLOGY SERVICES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	154,700	753,220	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		154,700	753,220			
H - HOSPITAL COSTS							
1.00	RURAL HEALTH CLINIC	88.00	0	1,900	0		1.00
	TOTALS		0	1,900			
I - CASE MANAGERS/DIRNSG							
1.00	ADMINISTRATIVE & GENERAL	5.00	54,663	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		54,663	0			
J - PROFESSIONAL SALARIES IN RHC							
1.00	RURAL HEALTH CLINIC	88.00	174,437	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		174,437	0			
K - IMPLANTABLE DEVICES							
1.00	OPERATING ROOM	50.00	0	46,925	0		1.00
	TOTALS		0	46,925			
500.00	Grand Total: Decreases		718,714	1,009,100			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/15/2013 10:38 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	1,894,987	0	0	0	2.00
3.00	Buildings and Fixtures	19,665,275	61,528	0	61,528	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	20,619,955	249,865	0	249,865	6.00
7.00	HIT designated Assets	1,778,038	293,347	0	293,347	7.00
8.00	Subtotal (sum of lines 1-7)	43,958,255	604,740	0	604,740	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	43,958,255	604,740	0	604,740	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,046,328	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,284,819	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,331,147	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	21,621,790	0	21,621,790	0.519783	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	19,975,930	0	19,975,930	0.480217	2.00
3.00	Total (sum of lines 1-2)	41,597,720	0	41,597,720	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0		1.00		
2.00	Land Improvements	1,894,987	0		2.00		
3.00	Buildings and Fixtures	19,726,803	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	19,975,930	0		6.00		
7.00	HIT designated Assets	2,071,385	0		7.00		
8.00	Subtotal (sum of lines 1-7)	43,669,105	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	43,669,105	0		10.00		
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,046,328		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,284,819		2.00		
3.00	Total (sum of lines 1-2)	0	4,331,147		3.00		
<b>ALLOCATION OF OTHER CAPITAL</b>							
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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,045,965	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	897,125	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,943,090	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141325

Period:  
From 10/01/2011  
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Worksheet A-7  
Parts I-III  
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Cost Center Description		SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
		11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT	-386,240	19,077	0	0	2,678,802	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	897,125	2.00	
3.00	Total (sum of lines 1-2)	-386,240	19,077	0	0	3,575,927	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8

Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-386,240	NEW CAP REL COSTS-BLDG & FIXT		1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP		2.00 2.00
3.00 Investment income - other (chapter 2)		0			0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00 7.00
8.00 Television and radio service (chapter 21)		0			0.00 8.00
9.00 Parking lot (chapter 21)		0			0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-2,197,286			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Cafeteria-employees and guests	B	-93,662	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	B	-1,611	MEDICAL RECORDS & LIBRARY		16.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts		0			0.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00 19.00
20.00 Vending machines		0			0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT		1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP		2.00 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00 28.00
29.00 Physicians' assistant		0			0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00 32.00
33.00 PROVIDER TAX	A	-429,552	ADMINISTRATIVE & GENERAL		5.00 33.00
33.01		0			0.00 33.01
33.08		0			0.00 33.08
33.14 MISC PT SALES	B	-18,976	PHYSICAL THERAPY		66.00 33.14
33.20 FITNESS FEES	B	-185	EMPLOYEE BENEFITS		4.00 33.20
33.23 MEDICAL STAFF FEES	B	-6,375	ADMINISTRATIVE & GENERAL		5.00 33.23
33.26 OTHER MISC INCOME	B	-427	ADMINISTRATIVE & GENERAL		5.00 33.26
34.00 MEDICAL STAFF DUES TRAVELING DR'S	B	-10,043	ADMINISTRATIVE & GENERAL		5.00 34.00
35.00		0			0.00 35.00
37.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00 37.00
38.00 PATIENT TELEPHONE COSTS - SALARIES	A	-1,870	ADMINISTRATIVE & GENERAL		5.00 38.00
39.00 PATIENT TELEPHONE COSTS - BENE	A	-481	EMPLOYEE BENEFITS		4.00 39.00
40.00 PATIENT TELEPHONE COSTS - OTHER	A	-817	ADMINISTRATIVE & GENERAL		5.00 40.00
41.00 PATIENT TELEPHONE COSTS - DEPRE	A	-363	NEW CAP REL COSTS-BLDG & FIXT		1.00 41.00
42.00 CRNA	A	-380,244	ANESTHESIOLOGY		53.00 42.00
43.00 LOBBYING PORTION OF DUES	A	-21,582	ADMINISTRATIVE & GENERAL		5.00 43.00
43.02 NON-REIMB EXP- ADMIN	A	-50	ADMINISTRATIVE & GENERAL		5.00 43.02
43.04		0			0.00 43.04
44.00 NON-ALLOWABLE ADVERTISING	A	-12,008	ADMINISTRATIVE & GENERAL		5.00 44.00

Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet A-8 Date/Time Prepared: 2/15/2013 10:38 am
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	
44.01 EMR EQUIPMENT DEPRECIATION EXPENSE	A	-387,694	NEW CAP REL COSTS-MVBLE EQUIP	2.00	44.01
44.02 PROVIDER TAX	A	429,552	ADMINISTRATIVE & GENERAL	5.00	44.02
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,519,914			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	PROVIDER TAX	0	33.00
33.01		0	33.01
33.08		0	33.08
33.14	MISC PT SALES	0	33.14
33.20	FITNESS FEES	0	33.20
33.23	MEDICAL STAFF FEES	0	33.23
33.26	OTHER MISC INCOME	0	33.26
34.00	MEDICAL STAFF DUES TRAVELING DR'S	0	34.00
35.00		0	35.00
37.00	OTHER ADJUSTMENTS (SPECIFY)	0	37.00
38.00	PATIENT TELEPHONE COSTS - SALARIES	0	38.00
39.00	PATIENT TELEPHONE COSTS - BENE	0	39.00
40.00	PATIENT TELEPHONE COSTS - OTHER	0	40.00
41.00	PATIENT TELEPHONE COSTS - DEPRE	9	41.00
42.00	CRNA	0	42.00
43.00	LOBBYING PORTION OF DUES	0	43.00
43.02	NON-REIMB EXP- ADMIN	0	43.02
43.04		0	43.04
44.00	NON-ALLOWABLE ADVERTISING	0	44.00
44.01	EMR EQUIPMENT DEPRECIATION EXPENSE	9	44.01
44.02	PROVIDER TAX	0	44.02
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/15/2013 10:38 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	60.00	LABORATORY	26,602	26,602	1.00
2.00	91.00	EMERGENCY	1,643,746	1,324,859	2.00
3.00	30.00	ADULTS & PEDIATRICS	630,000	630,000	3.00
4.00	30.00	ADULTS & PEDIATRICS	5,647	5,647	4.00
5.00	50.00	OPERATING ROOM	168,790	168,790	5.00
6.00	50.00	OPERATING ROOM	41,388	41,388	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			2,516,173	2,197,286	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/15/2013 10:38 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	318,887	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	318,887			0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	26,602	1.00
2.00	0	1,324,859	2.00
3.00	0	630,000	3.00
4.00	0	5,647	4.00
5.00	0	168,790	5.00
6.00	0	41,388	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	2,197,286	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,678,802	2,678,802			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	897,125		897,125		2.00
4.00 00400	EMPLOYEE BENEFITS	1,876,747	12,089	996	1,889,832	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,391,543	424,272	55,496	380,122	5,251,433
7.00 00700	OPERATION OF PLANT	911,629	225,934	12,890	54,950	1,205,403
8.00 00800	LAUNDRY & LINEN SERVICE	119,779	11,505	0	0	131,284
9.00 00900	HOUSEKEEPING	263,187	22,121	1,443	43,246	329,997
10.00 01000	DIETARY	118,411	61,583	9,444	14,629	204,067
11.00 01100	CAFETERIA	160,146	21,009	0	32,445	213,600
13.00 01300	NURSING ADMINISTRATION	108	8,004	0	0	8,112
14.00 01400	CENTRAL SERVICES & SUPPLY	44,888	0	11,214	4,767	60,869
15.00 01500	PHARMACY	653,683	37,822	4,432	33,199	729,136
16.00 01600	MEDICAL RECORDS & LIBRARY	289,330	52,329	2,499	44,438	388,596
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,163,736	501,750	43,964	206,145	1,915,595
31.00 03100	INTENSIVE CARE UNIT	137,448	70,920	11,686	21,027	241,081
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	880,095	266,368	98,991	124,132	1,369,586
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	25,031	3,752	3,210	76,196	108,189
54.00 05400	RADIOLOGY-DIAGNOSTIC	918,536	128,752	294,605	116,736	1,458,629
56.00 05600	RADIO SOTOPE	213,219	7,503	0	0	220,722
56.01 05602	ULTRASOUND	74,537	6,503	24,987	14,936	120,963
57.00 05700	CT SCAN	206,441	10,505	147,600	16,064	380,610
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	386,892	21,510	0	0	408,402
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	1,217,761	54,913	43,933	103,705	1,420,312
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	50,239	5,002	0	1,165	56,406
65.00 06500	RESPIRATORY THERAPY	218,845	15,507	0	33,502	267,854
66.00 06600	PHYSICAL THERAPY	516,621	93,597	8,331	98,810	717,359
67.00 06700	OCCUPATIONAL THERAPY	252,151	8,504	4,545	47,599	312,799
68.00 06800	SPEECH PATHOLOGY	139,937	3,001	1,112	26,176	170,226
69.01 06901	CARDIO-PULMONARY	109,224	46,243	22,421	21,200	199,088
69.02 06902	VASCULAR LAB	26,831	3,001	0	0	29,832
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	46,925	0	0	0	46,925
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01 07301	ONCOLOGY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	1,141,560	260,783	4,806	216,889	1,624,038
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	1,443,299	196,282	83,222	149,511	1,872,314
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
116.00 11600	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,574,706	2,581,064	891,827	1,881,589	21,463,427
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	51,674	25,428	293	1,118	78,513
190.01 19001	FOUNDATION	49,760	0	4,203	7,125	61,088
190.02 19002	DURABLE MEDICAL EQUIP-RENTED	29,846	0	161	0	30,007
192.00 19200	PHYSICIANS' PRIVATE OFFICES	14,453	72,310	641	0	87,404
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	21,720,439	2,678,802	897,125	1,889,832	21,720,439

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	5,251,433				5.00
7.00	00700	OPERATION OF PLANT	384,364	1,589,767			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,862	9,070	182,216		8.00
9.00	00900	HOUSEKEEPING	105,225	17,440	14,223	466,885	9.00
10.00	01000	DIETARY	65,070	48,551	304	21,986	339,978
11.00	01100	CAFETERIA	68,110	16,563	0	0	0
13.00	01300	NURSING ADMINISTRATION	2,587	6,310	0	3,141	0
14.00	01400	CENTRAL SERVICES & SUPPLY	19,409	0	134	3,510	0
15.00	01500	PHARMACY	232,498	29,818	0	8,314	0
16.00	01600	MEDICAL RECORDS & LIBRARY	123,911	41,255	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	610,819	395,567	65,461	204,160	318,175
31.00	03100	INTENSIVE CARE UNIT	76,873	55,912	1,841	6,651	21,803
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	436,717	209,999	14,832	53,765	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	34,498	2,958	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	465,110	101,505	11,543	31,778	0
56.00	05600	RADIOISOTOPE	70,381	5,915	0	0	0
56.01	05602	ULTRASOUND	38,571	5,127	0	0	0
57.00	05700	CT SCAN	121,364	8,282	0	4,988	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	130,226	16,958	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	452,892	43,292	0	19,954	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	17,986	3,944	0	0	0
65.00	06500	RESPIRATORY THERAPY	85,410	12,225	0	0	0
66.00	06600	PHYSICAL THERAPY	228,743	73,790	9,465	20,508	0
67.00	06700	OCCUPATIONAL THERAPY	99,742	6,704	0	2,771	0
68.00	06800	SPEECH PATHOLOGY	54,280	2,366	0	3,141	0
69.01	06901	CARDIO-PULMONARY	63,483	36,457	6,325	5,358	0
69.02	06902	VASCULAR LAB	9,512	2,366	0	4,619	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,963	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	ONCOLOGY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	517,854	205,595	0	17,367	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	597,021	154,744	58,088	39,354	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,169,481	1,512,713	182,216	451,365	339,978
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,035	20,047	0	0	0
190.01	19001	FOUNDATION	19,479	0	0	0	0
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	9,568	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,870	57,007	0	15,520	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	5,251,433	1,589,767	182,216	466,885	339,978

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	298,273					11.00
13.00	01300		20,150				13.00
14.00	01400	1,932	0	85,854			14.00
15.00	01500	6,038	732	0	1,006,536		15.00
16.00	01600	17,389	0	0	0	571,151	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	52,893	6,414	5,071	0	36,428	30.00
31.00	03100	4,347	527	1,429	0	4,550	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	19,563	2,372	53,355	0	66,543	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	4,830	0	0	0	16,107	53.00
54.00	05400	27,291	3,310	0	0	37,557	54.00
56.00	05600	4,830	586	0	0	9,652	56.00
56.01	05602	3,623	439	0	0	16,095	56.01
57.00	05700	0	0	0	0	68,166	57.00
58.00	05800	0	0	0	0	20,784	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	28,765	0	0	0	109,238	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	459	0	0	0	1,227	62.00
65.00	06500	9,319	1,130	0	0	23,540	65.00
66.00	06600	21,978	0	0	0	14,796	66.00
67.00	06700	8,212	0	0	0	4,346	67.00
68.00	06800	5,555	0	0	0	2,505	68.00
69.01	06901	5,896	715	964	0	14,896	69.01
69.02	06902	0	0	0	0	2,427	69.02
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	867	72.00
73.00	07300	0	0	0	1,006,536	27,516	73.00
73.01	07301	0	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	40,333	0	8,643	0	24,486	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	32,363	3,925	16,392	0	69,425	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	0	0	0	0	0	116.00
118.00		295,616	20,150	85,854	1,006,536	571,151	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	483	0	0	0	0	190.00
190.01	19001	2,174	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		298,273	20,150	85,854	1,006,536	571,151	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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
17.00	01700	SOCIAL SERVICE	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	3,610,583	0	3,610,583
31.00	03100	INTENSIVE CARE UNIT	0	415,014	0	415,014
41.00	04100	SUBPROVIDER - I RF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
43.00	04300	NURSERY	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	2,226,732	0	2,226,732
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	166,582	0	166,582
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,136,723	0	2,136,723
56.00	05600	RADIOISOTOPE	0	312,086	0	312,086
56.01	05602	ULTRASOUND	0	184,818	0	184,818
57.00	05700	CT SCAN	0	583,410	0	583,410
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	576,370	0	576,370
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	0	2,074,453	0	2,074,453
60.01	06001	BLOOD LABORATORY	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	80,022	0	80,022
65.00	06500	RESPIRATORY THERAPY	0	399,478	0	399,478
66.00	06600	PHYSICAL THERAPY	0	1,086,639	0	1,086,639
67.00	06700	OCCUPATIONAL THERAPY	0	434,574	0	434,574
68.00	06800	SPEECH PATHOLOGY	0	238,073	0	238,073
69.01	06901	CARDIO-PULMONARY	0	333,182	0	333,182
69.02	06902	VASCULAR LAB	0	48,756	0	48,756
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	62,755	0	62,755
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,034,052	0	1,034,052
73.01	07301	ONCOLOGY	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	2,438,316	0	2,438,316
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
91.00	09100	EMERGENCY	0	2,843,626	0	2,843,626
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0
99.10	09910	CORF	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	21,286,244	0	21,286,244
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	124,078	0	124,078
190.01	19001	FOUNDATION	0	82,741	0	82,741
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	39,575	0	39,575
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	187,801	0	187,801
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	21,720,439	0	21,720,439

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part II  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	12,089	996	13,085	13,085 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	424,272	55,496	479,768	2,636 5.00
7.00 00700	OPERATION OF PLANT	0	225,934	12,890	238,824	380 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,505	0	11,505	0 8.00
9.00 00900	HOUSEKEEPING	0	22,121	1,443	23,564	299 9.00
10.00 01000	DIETARY	0	61,583	9,444	71,027	101 10.00
11.00 01100	CAFETERIA	0	21,009	0	21,009	225 11.00
13.00 01300	NURSING ADMINISTRATION	0	8,004	0	8,004	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	11,214	11,214	33 14.00
15.00 01500	PHARMACY	0	37,822	4,432	42,254	230 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	52,329	2,499	54,828	308 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	501,750	43,964	545,714	1,427 30.00
31.00 03100	INTENSIVE CARE UNIT	0	70,920	11,686	82,606	146 31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	266,368	98,991	365,359	859 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	3,752	3,210	6,962	527 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	128,752	294,605	423,357	808 54.00
56.00 05600	RADIOISOTOPE	0	7,503	0	7,503	0 56.00
56.01 05602	ULTRASOUND	0	6,503	24,987	31,490	103 56.01
57.00 05700	CT SCAN	0	10,505	147,600	158,105	111 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,510	0	21,510	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	54,913	43,933	98,846	718 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,002	0	5,002	8 62.00
65.00 06500	RESPIRATORY THERAPY	0	15,507	0	15,507	232 65.00
66.00 06600	PHYSICAL THERAPY	0	93,597	8,331	101,928	684 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	8,504	4,545	13,049	329 67.00
68.00 06800	SPEECH PATHOLOGY	0	3,001	1,112	4,113	181 68.00
69.01 06901	CARDIO-PULMONARY	0	46,243	22,421	68,664	147 69.01
69.02 06902	VASCULAR LAB	0	3,001	0	3,001	0 69.02
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
73.01 07301	ONCOLOGY	0	0	0	0	0 73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	260,783	4,806	265,589	1,501 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00 09100	EMERGENCY	0	196,282	83,222	279,504	1,035 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
99.10 09910	CORF	0	0	0	0	0 99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,581,064	891,827	3,472,891	13,028 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,428	293	25,721	8 190.00
190.01 19001	FOUNDATION	0	0	4,203	4,203	49 190.01
190.02 19002	DURABLE MEDICAL EQUIP-RENTED	0	0	161	161	0 190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	72,310	641	72,951	0 192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	2,678,802	897,125	3,575,927	13,085 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/15/2013 10:38 am			
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	482,404			5.00	
7.00	00700	OPERATION OF PLANT	35,309	274,513		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	3,846	1,566	16,917	8.00	
9.00	00900	HOUSEKEEPING	9,666	3,011	1,320	37,860	
10.00	01000	DIETARY	5,978	8,383	28	1,783	87,300
11.00	01100	CAFETERIA	6,257	2,860	0	0	
13.00	01300	NURSING ADMINISTRATION	238	1,090	0	255	
14.00	01400	CENTRAL SERVICES & SUPPLY	1,783	0	12	285	
15.00	01500	PHARMACY	21,358	5,149	0	674	
16.00	01600	MEDICAL RECORDS & LIBRARY	11,383	7,124	0	0	
17.00	01700	SOCIAL SERVICE	0	0	0	0	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	56,103	68,303	6,078	16,554	81,701
31.00	03100	INTENSIVE CARE UNIT	7,062	9,655	171	539	5,599
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	40,118	36,262	1,377	4,360	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	3,169	511	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,726	17,527	1,072	2,577	0
56.00	05600	RADIOISOTOPE	6,465	1,021	0	0	0
56.01	05602	ULTRASOUND	3,543	885	0	0	0
57.00	05700	CT SCAN	11,149	1,430	0	405	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,963	2,928	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	41,604	7,476	0	1,618	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,652	681	0	0	0
65.00	06500	RESPIRATORY THERAPY	7,846	2,111	0	0	0
66.00	06600	PHYSICAL THERAPY	21,013	12,742	879	1,663	0
67.00	06700	OCCUPATIONAL THERAPY	9,163	1,158	0	225	0
68.00	06800	SPEECH PATHOLOGY	4,986	409	0	255	0
69.01	06901	CARDIO-PULMONARY	5,832	6,295	587	434	0
69.02	06902	VASCULAR LAB	874	409	0	375	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,375	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	ONCOLOGY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	47,571	35,501	0	1,408	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	54,844	26,720	5,393	3,191	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	474,876	261,207	16,917	36,601	87,300
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,300	3,462	0	0	0
190.01	19001	FOUNDATION	1,789	0	0	0	0
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	879	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,560	9,844	0	1,259	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	482,404	274,513	16,917	37,860	87,300

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/15/2013 10:38 am
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	30,351					11.00
13.00	01300		9,587				13.00
14.00	01400	197	0	13,524			14.00
15.00	01500	614	348	0	70,627		15.00
16.00	01600	1,769	0	0	0	75,412	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,382	3,051	799	0	4,809	30.00
31.00	03100	442	251	225	0	601	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,991	1,129	8,405	0	8,785	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	492	0	0	0	2,126	53.00
54.00	05400	2,777	1,575	0	0	4,958	54.00
56.00	05600	492	279	0	0	1,274	56.00
56.01	05602	369	209	0	0	2,125	56.01
57.00	05700	0	0	0	0	8,999	57.00
58.00	05800	0	0	0	0	2,744	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2,927	0	0	0	14,431	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	47	0	0	0	162	62.00
65.00	06500	948	538	0	0	3,108	65.00
66.00	06600	2,236	0	0	0	1,953	66.00
67.00	06700	836	0	0	0	574	67.00
68.00	06800	565	0	0	0	331	68.00
69.01	06901	600	340	152	0	1,966	69.01
69.02	06902	0	0	0	0	320	69.02
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	115	72.00
73.00	07300	0	0	0	70,627	3,633	73.00
73.01	07301	0	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	4,104	0	1,361	0	3,233	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	3,293	1,867	2,582	0	9,165	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	0	0	0	0	0	116.00
118.00		30,081	9,587	13,524	70,627	75,412	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	49	0	0	0	0	190.00
190.01	19001	221	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		30,351	9,587	13,524	70,627	75,412	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/15/2013 10:38 am
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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
17.00	01700	SOCIAL SERVICE	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	789,921	0	789,921
31.00	03100	INTENSIVE CARE UNIT	0	107,297	0	107,297
41.00	04100	SUBPROVIDER - I RF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
43.00	04300	NURSERY	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	468,645	0	468,645
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	13,787	0	13,787
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	497,377	0	497,377
56.00	05600	RADIOISOTOPE	0	17,034	0	17,034
56.01	05602	ULTRASOUND	0	38,724	0	38,724
57.00	05700	CT SCAN	0	180,199	0	180,199
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	39,145	0	39,145
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	0	167,620	0	167,620
60.01	06001	BLOOD LABORATORY	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7,552	0	7,552
65.00	06500	RESPIRATORY THERAPY	0	30,290	0	30,290
66.00	06600	PHYSICAL THERAPY	0	143,098	0	143,098
67.00	06700	OCCUPATIONAL THERAPY	0	25,334	0	25,334
68.00	06800	SPEECH PATHOLOGY	0	10,840	0	10,840
69.01	06901	CARDIO-PULMONARY	0	85,017	0	85,017
69.02	06902	VASCULAR LAB	0	4,979	0	4,979
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,490	0	1,490
73.00	07300	DRUGS CHARGED TO PATIENTS	0	74,260	0	74,260
73.01	07301	ONCOLOGY	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	360,268	0	360,268
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
91.00	09100	EMERGENCY	0	387,594	0	387,594
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0
99.10	09910	CORF	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,450,471	0	3,450,471
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,540	0	31,540
190.01	19001	FOUNDATION	0	6,262	0	6,262
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	1,040	0	1,040
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	86,614	0	86,614
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	3,575,927	0	3,575,927

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (MME DEPRE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	96,394					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		1,179,794				2.00
4.00 00400	EMPLOYEE BENEFITS	435	1,310	9,430,943			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,267	72,982	1,896,936	-5,251,433	16,469,006	5.00
7.00 00700	OPERATION OF PLANT	8,130	16,952	274,219	0	1,205,403	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	414	0	0	0	131,284	8.00
9.00 00900	HOUSEKEEPING	796	1,898	215,815	0	329,997	9.00
10.00 01000	DIETARY	2,216	12,419	73,005	0	204,067	10.00
11.00 01100	CAFETERIA	756	0	161,912	0	213,600	11.00
13.00 01300	NURSING ADMINISTRATION	288	0	0	0	8,112	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	14,747	23,791	0	60,869	14.00
15.00 01500	PHARMACY	1,361	5,828	165,673	0	729,136	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,883	3,286	221,761	0	388,596	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	18,055	57,816	1,028,742	0	1,915,595	30.00
31.00 03100	INTENSIVE CARE UNIT	2,552	15,368	104,933	0	241,081	31.00
41.00 04100	SUBPROVIDER - IIRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	9,585	130,181	619,465	0	1,369,586	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	135	4,221	380,244	0	108,189	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,633	387,434	582,555	0	1,458,629	54.00
56.00 05600	RADIOISOTOPE	270	0	0	0	220,722	56.00
56.01 05602	ULTRASOUND	234	32,860	74,537	0	120,963	56.01
57.00 05700	CT SCAN	378	194,106	80,163	0	380,610	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	408,402	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	1,976	57,775	517,525	0	1,420,312	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	5,815	0	56,406	62.00
65.00 06500	RESPIRATORY THERAPY	558	0	167,187	0	267,854	65.00
66.00 06600	PHYSICAL THERAPY	3,368	10,956	493,098	0	717,359	66.00
67.00 06700	OCCUPATIONAL THERAPY	306	5,977	237,539	0	312,799	67.00
68.00 06800	SPEECH PATHOLOGY	108	1,462	130,628	0	170,226	68.00
69.01 06901	CARDIO-PULMONARY	1,664	29,485	105,794	0	199,088	69.01
69.02 06902	VASCULAR LAB	108	0	0	0	29,832	69.02
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	46,925	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 07301	ONCOLOGY	0	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	9,384	6,320	1,082,355	0	1,624,038	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	7,063	109,444	746,117	0	1,872,314	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 11600	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	92,877	1,172,827	9,389,809	-5,251,433	16,211,994	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	385	5,577	0	78,513	190.00
190.01 19001	FOUNDATION	0	5,527	35,557	0	61,088	190.01
190.02 19002	DURABLE MEDICAL EQUIP-RENTED	0	212	0	0	30,007	190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,602	843	0	0	87,404	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,678,802	897,125	1,889,832		5,251,433	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	27.790132	0.760408	0.200386		0.318868	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (MME DEPRE)					
		1.00	2.00	4.00				
204.00	Cost to be allocated (per Wkst. B, Part II)			13,085	5A	482,404	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001387		0.029292	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	72,562				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	414	24,546			8.00	
9.00	00900	HOUSEKEEPING	796	1,916	2,527		9.00	
10.00	01000	DIETARY	2,216	41	119	1,762	10.00	
11.00	01100	CAFETERIA	756	0	0	256,880	11.00	
13.00	01300	NURSING ADMINISTRATION	288	0	17	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18	19	0	14.00	
15.00	01500	PHARMACY	1,361	0	45	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	18,055	8,818	1,105	1,649	45,552	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	248	36	113	3,744	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	9,585	1,998	291	0	16,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	0	0	0	4,160	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,633	1,555	172	0	23,504	54.00
56.00	05600	RADIOISOTOPE	270	0	0	0	4,160	56.00
56.01	05602	ULTRASOUND	234	0	0	0	3,120	56.01
57.00	05700	CT SCAN	378	0	27	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	0	108	0	24,773	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	0	0	395	62.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	8,026	65.00
66.00	06600	PHYSICAL THERAPY	3,368	1,275	111	0	18,928	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	15	0	7,072	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	17	0	4,784	68.00
69.01	06901	CARDIO-PULMONARY	1,664	852	29	0	5,078	69.01
69.02	06902	VASCULAR LAB	108	0	25	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	9,384	0	94	0	34,736	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	7,825	213	0	27,872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,045	24,546	2,443	1,762	254,592	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	0	0	0	416	190.00
190.01	19001	FOUNDATION	0	0	0	0	1,872	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	84	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,589,767	182,216	466,885	339,978	298,273	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.909085	7.423450	184.758607	192.950057	1.161137	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	274,513	16,917	37,860	87,300	30,351	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	3.783151	0.689196	14.982192	49.545970	0.118152	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		NURSING ADMINISTRATION  (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (TIME SPENT)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE  (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	143,104					13.00
14.00	01400	0	2,404				14.00
15.00	01500	5,200	0	100			15.00
16.00	01600	0	0	0	46,715,322		16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	45,552	142	0	2,979,529	0	30.00
31.00	03100	3,744	40	0	372,182	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	16,848	1,494	0	5,442,780	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	1,317,439	0	53.00
54.00	05400	23,504	0	0	3,071,898	0	54.00
56.00	05600	4,160	0	0	789,434	0	56.00
56.01	05602	3,120	0	0	1,316,453	0	56.01
57.00	05700	0	0	0	5,575,460	0	57.00
58.00	05800	0	0	0	1,699,982	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	8,934,065	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	100,378	0	62.00
65.00	06500	8,026	0	0	1,925,401	0	65.00
66.00	06600	0	0	0	1,210,212	0	66.00
67.00	06700	0	0	0	355,461	0	67.00
68.00	06800	0	0	0	204,920	0	68.00
69.01	06901	5,078	27	0	1,218,375	0	69.01
69.02	06902	0	0	0	198,488	0	69.02
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	70,955	0	72.00
73.00	07300	0	0	100	2,250,652	0	73.00
73.01	07301	0	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	242	0	2,002,806	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	27,872	459	0	5,678,452	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	0	0	0	0	0	116.00
118.00		143,104	2,404	100	46,715,322	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		20,150	85,854	1,006,536	571,151	0	202.00
203.00		0.140807	35.712978	10,065.360000	0.012226	0.000000	203.00
204.00		9,587	13,524	70,627	75,412	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE  (TIME SPENT)	
		(NURSING FTE'S)	(TIME SPENT)				
205.00	Unit cost multiplier (Wkst. B, Part II)	0.066993	5.625624	706.270000	0.001614	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	3,610,583	3,610,583	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	415,014	415,014	0	0	31.00
41.00	04100 SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	42.00
43.00	04300 NURSERY	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	2,226,732	2,226,732	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	166,582	166,582	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,136,723	2,136,723	0	0	54.00
56.00	05600 RADIOISOTOPE	312,086	312,086	0	0	56.00
56.01	05602 ULTRASOUND	184,818	184,818	0	0	56.01
57.00	05700 CT SCAN	583,410	583,410	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	576,370	576,370	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000 LABORATORY	2,074,453	2,074,453	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	80,022	80,022	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	399,478	399,478	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,086,639	1,086,639	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	434,574	434,574	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	238,073	238,073	0	0	68.00
69.01	06901 CARDIO-PULMONARY	333,182	333,182	0	0	69.01
69.02	06902 VASCULAR LAB	48,756	48,756	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	62,755	62,755	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,034,052	1,034,052	0	0	73.00
73.01	07301 ONCOLOGY	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	2,438,316	2,438,316	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100 EMERGENCY	2,843,626	2,843,626	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	532,335	532,335	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
99.10	09910 CORF	0	0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	111.00
116.00	11600 HOSPICE	0	0	0	0	116.00
200.00	Subtotal (see instructions)	21,818,579	21,818,579	0	0	200.00
201.00	Less Observation Beds	532,335	532,335	0	0	201.00
202.00	Total (see instructions)	21,286,244	21,286,244	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,607,607		2,607,607		30.00
31.00	03100	INTENSIVE CARE UNIT	372,182		372,182		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	598,958	4,843,822	5,442,780	0.409117	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	224,001	1,093,438	1,317,439	0.126444	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,217	2,963,681	3,071,898	0.695571	54.00
56.00	05600	RADIOISOTOPE	65,027	724,407	789,434	0.395329	56.00
56.01	05602	ULTRASOUND	20,540	1,295,913	1,316,453	0.140391	56.01
57.00	05700	CT SCAN	147,417	5,428,043	5,575,460	0.104639	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,263	1,678,719	1,699,982	0.339045	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	632,589	8,301,476	8,934,065	0.232196	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	37,794	62,584	100,378	0.797207	62.00
65.00	06500	RESPIRATORY THERAPY	1,258,623	666,778	1,925,401	0.207478	65.00
66.00	06600	PHYSICAL THERAPY	214,312	995,900	1,210,212	0.897891	66.00
67.00	06700	OCCUPATIONAL THERAPY	150,375	205,086	355,461	1.222565	67.00
68.00	06800	SPEECH PATHOLOGY	15,683	189,237	204,920	1.161785	68.00
69.01	06901	CARDIO-PULMONARY	151,241	1,067,134	1,218,375	0.273464	69.01
69.02	06902	VASCULAR LAB	17,220	181,268	198,488	0.245637	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70,955	70,955	0.884434	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	876,753	1,373,899	2,250,652	0.459446	73.00
73.01	07301	ONCOLOGY	0	0	0	0.000000	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	2,002,806	2,002,806		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	240,843	5,437,609	5,678,452	0.500775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,516	370,406	371,922	1.431308	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	7,762,161	38,953,161	46,715,322		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	7,762,161	38,953,161	46,715,322		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/15/2013 10:38 am
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
56.01	05602	ULTRASOUND	0.000000	56.01
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.01	06901	CARDIO-PULMONARY	0.000000	69.01
69.02	06902	VASCULAR LAB	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
73.01	07301	ONCOLOGY	0.000000	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900	PANCREAS ACQUISITION		109.00
110.00	11000	INTESTINAL ACQUISITION		110.00
111.00	11100	ISLET ACQUISITION		111.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

		Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs					
			Total Costs	RCE Disallowance	Total Costs			
			1.00	2.00	3.00		4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,610,583		3,610,583	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	415,014		415,014	0	0	31.00
41.00	04100	SUBPROVIDER - I RF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,226,732		2,226,732	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	166,582		166,582	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,136,723		2,136,723	0	0	54.00
56.00	05600	RADIOISOTOPE	312,086		312,086	0	0	56.00
56.01	05602	ULTRASOUND	184,818		184,818	0	0	56.01
57.00	05700	CT SCAN	583,410		583,410	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	576,370		576,370	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,074,453		2,074,453	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	80,022		80,022	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	399,478	0	399,478	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,086,639	0	1,086,639	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	434,574	0	434,574	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	238,073	0	238,073	0	0	68.00
69.01	06901	CARDIO-PULMONARY	333,182		333,182	0	0	69.01
69.02	06902	VASCULAR LAB	48,756		48,756	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,755		62,755	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,034,052		1,034,052	0	0	73.00
73.01	07301	ONCOLOGY	0		0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	2,438,316		2,438,316	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	2,843,626		2,843,626	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	532,335		532,335	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
116.00	11600	HOSPICE	0		0	0	0	116.00
200.00		Subtotal (see instructions)	21,818,579	0	21,818,579	0	0	200.00
201.00		Less Observation Beds	532,335		532,335			201.00
202.00		Total (see instructions)	21,286,244	0	21,286,244	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,607,607		2,607,607		30.00
31.00	03100	INTENSIVE CARE UNIT	372,182		372,182		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	598,958	4,843,822	5,442,780	0.409117	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	224,001	1,093,438	1,317,439	0.126444	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,217	2,963,681	3,071,898	0.695571	54.00
56.00	05600	RADIOISOTOPE	65,027	724,407	789,434	0.395329	56.00
56.01	05602	ULTRASOUND	20,540	1,295,913	1,316,453	0.140391	56.01
57.00	05700	CT SCAN	147,417	5,428,043	5,575,460	0.104639	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,263	1,678,719	1,699,982	0.339045	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	632,589	8,301,476	8,934,065	0.232196	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	37,794	62,584	100,378	0.797207	62.00
65.00	06500	RESPIRATORY THERAPY	1,258,623	666,778	1,925,401	0.207478	65.00
66.00	06600	PHYSICAL THERAPY	214,312	995,900	1,210,212	0.897891	66.00
67.00	06700	OCCUPATIONAL THERAPY	150,375	205,086	355,461	1.222565	67.00
68.00	06800	SPEECH PATHOLOGY	15,683	189,237	204,920	1.161785	68.00
69.01	06901	CARDIO-PULMONARY	151,241	1,067,134	1,218,375	0.273464	69.01
69.02	06902	VASCULAR LAB	17,220	181,268	198,488	0.245637	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	70,955	70,955	0.884434	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	876,753	1,373,899	2,250,652	0.459446	73.00
73.01	07301	ONCOLOGY	0	0	0	0.000000	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	2,002,806	2,002,806	1.217450	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	240,843	5,437,609	5,678,452	0.500775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,516	370,406	371,922	1.431308	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
99.10	09910	CORF	0	0	0	0.000000	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	7,762,161	38,953,161	46,715,322		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	7,762,161	38,953,161	46,715,322		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
56.01	05602 ULTRASOUND	0.000000			56.01
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.01	06901 CARDIO-PULMONARY	0.000000			69.01
69.02	06902 VASCULAR LAB	0.000000			69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301 ONCOLOGY	0.000000			73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
99.10	09910 CORF				99.10
101.00	10100 HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
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 ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/15/2013 10:38 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	468,645	5,442,780	0.086104	235,152	20,248	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	13,787	1,317,439	0.010465	96,711	1,012	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	497,377	3,071,898	0.161912	78,466	12,705	54.00
56.00	05600 RADIOISOTOPE	17,034	789,434	0.021577	53,837	1,162	56.00
56.01	05602 ULTRASOUND	38,724	1,316,453	0.029415	12,848	378	56.01
57.00	05700 CT SCAN	180,199	5,575,460	0.032320	72,005	2,327	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	39,145	1,699,982	0.023027	15,396	355	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	167,620	8,934,065	0.018762	414,248	7,772	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7,552	100,378	0.075236	18,726	1,409	62.00
65.00	06500 RESPIRATORY THERAPY	30,290	1,925,401	0.015732	1,042,948	16,408	65.00
66.00	06600 PHYSICAL THERAPY	143,098	1,210,212	0.118242	110,640	13,082	66.00
67.00	06700 OCCUPATIONAL THERAPY	25,334	355,461	0.071271	73,798	5,260	67.00
68.00	06800 SPEECH PATHOLOGY	10,840	204,920	0.052899	7,680	406	68.00
69.01	06901 CARDIO-PULMONARY	85,017	1,218,375	0.069779	24,969	1,742	69.01
69.02	06902 VASCULAR LAB	4,979	198,488	0.025085	11,699	293	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,490	70,955	0.020999	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	74,260	2,250,652	0.032995	498,821	16,459	73.00
73.01	07301 ONCOLOGY	0	0	0.000000	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	360,268	2,002,806	0.179882	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	387,594	5,678,452	0.068257	13,618	930	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	371,922	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	2,553,253	43,735,533		2,781,562	101,948	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/15/2013 10:38 am
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Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05602	ULTRASOUND	0	0	0	0	0	56.01
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
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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
69.01	06901	CARDIO-PULMONARY	0	0	0	0	0	69.01
69.02	06902	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/15/2013 10:38 am
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	5,442,780	0.000000	0.000000	235,152	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,317,439	0.000000	0.000000	96,711	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,071,898	0.000000	0.000000	78,466	54.00
56.00	05600 RADIOISOTOPE	0	789,434	0.000000	0.000000	53,837	56.00
56.01	05602 ULTRASOUND	0	1,316,453	0.000000	0.000000	12,848	56.01
57.00	05700 CT SCAN	0	5,575,460	0.000000	0.000000	72,005	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,699,982	0.000000	0.000000	15,396	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	8,934,065	0.000000	0.000000	414,248	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	100,378	0.000000	0.000000	18,726	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,925,401	0.000000	0.000000	1,042,948	65.00
66.00	06600 PHYSICAL THERAPY	0	1,210,212	0.000000	0.000000	110,640	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	355,461	0.000000	0.000000	73,798	67.00
68.00	06800 SPEECH PATHOLOGY	0	204,920	0.000000	0.000000	7,680	68.00
69.01	06901 CARDIO-PULMONARY	0	1,218,375	0.000000	0.000000	24,969	69.01
69.02	06902 VASCULAR LAB	0	198,488	0.000000	0.000000	11,699	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	70,955	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,250,652	0.000000	0.000000	498,821	73.00
73.01	07301 ONCOLOGY	0	0	0.000000	0.000000	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	2,002,806	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	5,678,452	0.000000	0.000000	13,618	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	371,922	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	43,735,533			2,781,562	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/15/2013 10:38 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
56.01	05602 ULTRASOUND	0	0	0		56.01
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.01	06901 CARDIO-PULMONARY	0	0	0		69.01
69.02	06902 VASCULAR LAB	0	0	0		69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	07301 ONCOLOGY	0	0	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/15/2013 10:38 am
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Cost
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.409117	0	2,370,282	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.126444	0	475,388	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.695571	0	1,012,642	0	54.00
56.00 05600 RADIOISOTOPE	0.395329	0	283,636	0	56.00
56.01 05602 ULTRASOUND	0.140391	0	237,577	0	56.01
57.00 05700 CT SCAN	0.104639	0	2,018,489	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.339045	0	534,156	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 06000 LABORATORY	0.232196	0	3,380,470	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.797207	0	32,938	0	62.00
65.00 06500 RESPIRATORY THERAPY	0.207478	0	355,920	0	65.00
66.00 06600 PHYSICAL THERAPY	0.897891	0	389,584	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	1.222565	0	63,478	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.161785	0	61,951	0	68.00
69.01 06901 CARDIO-PULMONARY	0.273464	0	346,488	0	69.01
69.02 06902 VASCULAR LAB	0.245637	0	110,671	0	69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.884434	0	46,764	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.459446	0	646,016	3,722	73.00
73.01 07301 ONCOLOGY	0.000000	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00 09100 EMERGENCY	0.500775	0	1,768,055	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.431308	0	178,966	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
200.00	Subtotal (see instructions)	0	14,313,471	3,722	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	14,313,471	3,722	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/15/2013 10:38 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	969,723	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	60,110	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	704,364	0	54.00
56.00	05600	RADIOISOTOPE	0	112,130	0	56.00
56.01	05602	ULTRASOUND	0	33,354	0	56.01
57.00	05700	CT SCAN	0	211,213	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	181,103	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	784,932	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	26,258	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	73,846	0	65.00
66.00	06600	PHYSICAL THERAPY	0	349,804	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	77,606	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	71,974	0	68.00
69.01	06901	CARDIO-PULMONARY	0	94,752	0	69.01
69.02	06902	VASCULAR LAB	0	27,185	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	41,360	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	296,809	1,710	73.00
73.01	07301	ONCOLOGY	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100	EMERGENCY	0	885,398	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	256,155	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Subtotal (see instructions)	0	5,258,076	1,710	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	5,258,076	1,710	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/15/2013 10:38 am
		Component CCN: 14Z325	Title XVIII	Swing Beds - SNF

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			1.00	2.00		3.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.409117	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.126444	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.695571	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.395329	0	0	0	56.00
56.01	05602 ULTRASOUND	0.140391	0	0	0	56.01
57.00	05700 CT SCAN	0.104639	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.339045	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.232196	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.797207	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.207478	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.897891	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.222565	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.161785	0	0	0	68.00
69.01	06901 CARDIO-PULMONARY	0.273464	0	0	0	69.01
69.02	06902 VASCULAR LAB	0.245637	0	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.884434	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.459446	0	0	0	73.00
73.01	07301 ONCOLOGY	0.000000	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00	09100 EMERGENCY	0.500775	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.431308	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141325 Component CCN: 14Z325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/15/2013 10:38 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				Cost	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
56.01	05602	ULTRASOUND	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.01	06901	CARDIO-PULMONARY	0	0	0	69.01
69.02	06902	VASCULAR LAB	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Subtotal (see instructions)	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/15/2013 10:38 am
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	1.00	2.00	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.409117	0	758,025	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.126444	0	299,699	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.695571	0	749,953	0	54.00
56.00 05600 RADIOISOTOPE	0.395329	0	183,310	0	56.00
56.01 05602 ULTRASOUND	0.140391	0	327,928	0	56.01
57.00 05700 CT SCAN	0.104639	0	1,373,555	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.339045	0	424,796	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 06000 LABORATORY	0.232196	0	1,881,570	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.797207	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0.207478	0	310,858	0	65.00
66.00 06600 PHYSICAL THERAPY	0.897891	0	166,921	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	1.222565	0	31,805	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.161785	0	33,169	0	68.00
69.01 06901 CARDIO-PULMONARY	0.273464	0	0	0	69.01
69.02 06902 VASCULAR LAB	0.245637	0	0	0	69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.884434	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.459446	0	263,075	0	73.00
73.01 07301 ONCOLOGY	0.000000	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	1.217450				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00 09100 EMERGENCY	0.500775	0	3,063,013	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.431308	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
200.00 Subtotal (see instructions)		0	9,867,677	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	9,867,677	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/15/2013 10:38 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	310,121	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	37,895	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	521,646	0	54.00
56.00	05600	RADIOISOTOPE	0	72,468	0	56.00
56.01	05602	ULTRASOUND	0	46,038	0	56.01
57.00	05700	CT SCAN	0	143,727	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	144,025	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	436,893	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	64,496	0	65.00
66.00	06600	PHYSICAL THERAPY	0	149,877	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	38,884	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	38,535	0	68.00
69.01	06901	CARDIO-PULMONARY	0	0	0	69.01
69.02	06902	VASCULAR LAB	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	120,869	0	73.00
73.01	07301	ONCOLOGY	0	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100	EMERGENCY	0	1,533,880	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Subtotal (see instructions)	0	3,659,354	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,659,354	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/15/2013 10:38 am
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,326	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,988	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)		1,649	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		75	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)		234	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		9	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)		20	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,115	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)		75	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)		226	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.34	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.34	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,610,583	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		1,110	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)		2,467	25.00
26.00	Total swing-bed cost (see instructions)		488,803	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,121,780	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,640,364	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,640,364	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.182329	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)		1,601.19	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,121,780	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,570.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,750,896	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)		1,750,896	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
Date/Time Prepared: 2/15/2013 10:38 am		Title XVIII		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	415,014	113	3,672.69	76	279,124		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					970,551		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,000,571		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					117,773		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					354,890		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					472,663		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)						339	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,570.31	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						532,335	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D-1  
Date/Time Prepared:  
2/15/2013 10:38 am

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/15/2013 10:38 am
Cost Center Description				Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,326	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,988	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)		1,649	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		75	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)		234	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		9	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)		20	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		211	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.34	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.34	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,610,583	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		1,110	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)		2,467	25.00
26.00	Total swing-bed cost (see instructions)		488,803	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,121,780	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,640,364	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,640,364	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.182329	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)		1,601.19	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,121,780	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,570.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		331,335	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)		331,335	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
Date/Time Prepared: 2/15/2013 10:38 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	415,014	113	3,672.69	1	3,673		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					271,769		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					606,777		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						339	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,570.31	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						532,335	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D-1

Date/Time Prepared:  
2/15/2013 10:38 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/15/2013 10:38 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		1,465,861		30.00
31.00	03100 INTENSIVE CARE UNIT		231,296		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.409117	235,152	96,205	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.126444	96,711	12,229	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.695571	78,466	54,579	54.00
56.00	05600 RADIOISOTOPE	0.395329	53,837	21,283	56.00
56.01	05602 ULTRASOUND	0.140391	12,848	1,804	56.01
57.00	05700 CT SCAN	0.104639	72,005	7,535	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.339045	15,396	5,220	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.232196	414,248	96,187	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.797207	18,726	14,928	62.00
65.00	06500 RESPIRATORY THERAPY	0.207478	1,042,948	216,389	65.00
66.00	06600 PHYSICAL THERAPY	0.897891	110,640	99,343	66.00
67.00	06700 OCCUPATIONAL THERAPY	1.222565	73,798	90,223	67.00
68.00	06800 SPEECH PATHOLOGY	1.161785	7,680	8,923	68.00
69.01	06901 CARDIO-PULMONARY	0.273464	24,969	6,828	69.01
69.02	06902 VASCULAR LAB	0.245637	11,699	2,874	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.884434	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.459446	498,821	229,181	73.00
73.01	07301 ONCOLOGY	0.000000	0	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	0.500775	13,618	6,820	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.431308	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		2,781,562	970,551	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)		2,781,562		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3	
		Component CCN: 14Z325		Date/Time Prepared: 2/15/2013 10:38 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		283,034	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.409117	1,658	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.126444	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.695571	2,868	54.00
56.00	05600	RADIOISOTOPE	0.395329	0	56.00
56.01	05602	ULTRASOUND	0.140391	859	56.01
57.00	05700	CT SCAN	0.104639	1,632	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.339045	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.232196	24,101	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.797207	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.207478	69,324	65.00
66.00	06600	PHYSICAL THERAPY	0.897891	70,277	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.222565	56,338	67.00
68.00	06800	SPEECH PATHOLOGY	1.161785	5,125	68.00
69.01	06901	CARDIO-PULMONARY	0.273464	2,621	69.01
69.02	06902	VASCULAR LAB	0.245637	1,983	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.884434	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.459446	72,086	73.00
73.01	07301	ONCOLOGY	0.000000	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.500775	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.431308	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		308,872	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)		308,872	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/15/2013 10:38 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		328,560	30.00
31.00	03100	INTENSIVE CARE UNIT		40,537	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.409117	184,907	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.126444	98,778	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.695571	10,697	54.00
56.00	05600	RADIOISOTOPE	0.395329	6,428	56.00
56.01	05602	ULTRASOUND	0.140391	2,030	56.01
57.00	05700	CT SCAN	0.104639	14,572	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.339045	2,102	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.232196	85,223	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.797207	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.207478	137,539	65.00
66.00	06600	PHYSICAL THERAPY	0.897891	2,970	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.222565	1,200	67.00
68.00	06800	SPEECH PATHOLOGY	1.161785	732	68.00
69.01	06901	CARDIO-PULMONARY	0.273464	0	69.01
69.02	06902	VASCULAR LAB	0.245637	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.884434	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.459446	116,777	73.00
73.01	07301	ONCOLOGY	0.000000	0	73.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	1.217450	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
91.00	09100	EMERGENCY	0.500775	128,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.431308	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		792,084	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)		792,084	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/15/2013 10:38 am
		Title VIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			5,259,786 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,259,786 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,312,384 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			26,705 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,170,125 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			3,115,554 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,115,554 30.00
31.00	Primary payer payments			296 31.00
32.00	Subtotal (line 30 minus line 31)			3,115,258 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			644,933 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			644,933 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			604,203 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,760,191 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,760,191 40.00
41.00	Interim payments			3,809,567 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)			-49,376 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			105,351 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,553,544		3,762,251	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	05/18/2012	307,220	05/18/2012	71,120	3.01	
3.02		09/21/2012	69,232		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	09/21/2012	23,804	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)		376,452		47,316	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,929,996		3,809,567	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		143,297		49,376	6.02	
7.00	Total Medicare program liability (see instructions)		2,786,699		3,760,191	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141325  
Component CCN: 14Z325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/15/2013 10:38 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		574,106		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	05/18/2012	53,036		0	3.01
3.02		09/21/2012	10,831		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)		63,867		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)		637,973		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		35,994		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		673,967		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet E-1  
Part II  
Date/Time Prepared:  
2/15/2013 10:38 am

		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			612 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,191 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			96 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,762 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			46,715,322 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,553,372 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			293,347 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			285,283 8.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			285,283 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet E-2	
		Component CCN: 14Z325		Date/Time Prepared: 2/15/2013 10:38 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		477,390	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		197,152	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		301	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		674,542	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		674,542	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		674,542	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		575	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		673,967	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
17.00	Reimbursable bad debts (see instructions)		0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		673,967	0	19.00
20.00	Interim payments		637,973	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		35,994	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		13,482	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part V Date/Time Prepared: 2/15/2013 10:38 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services			3,000,571 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			3,000,571 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,030,577 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3,030,577 19.00
20.00	Deductibles (exclude professional component)			325,636 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			2,704,941 22.00
23.00	Coinsurance			2,305 23.00
24.00	Subtotal (line 22 minus line 23)			2,702,636 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			84,063 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			84,063 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			70,780 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,786,699 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,786,699 30.00
31.00	Interim payments			2,929,996 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			-143,297 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			62,458 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 2/15/2013 10:38 am	
		Title XIX	Hospital	Cost	
		Inpatient	Outpatient		
		1.00	2.00		
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services	606,777			1.00
2.00	Medical and other services		3,659,354		2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	606,777	3,659,354		4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments		0		6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	606,777	3,659,354		7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges	369,097			8.00
9.00	Ancillary service charges	792,084	9,867,677		9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,161,181	9,867,677		12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0		13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0		14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000		15.00
16.00	Total customary charges (see instructions)	1,161,181	9,867,677		16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	554,404	6,208,323		17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0		18.00
19.00	Interns and Residents (see instructions)	0	0		19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0		20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	606,777	3,659,354		21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments	0	0		22.00
23.00	Outlier payments	0	0		23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0	0		26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0		27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	606,777	3,659,354		29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)	0	0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	606,777	3,659,354		31.00
32.00	Deductibles	0	0		32.00
33.00	Coinurance	0	0		33.00
34.00	Allowable bad debts (see instructions)	0	0		34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	606,777	3,659,354		36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		37.00
38.00	Subtotal (line 36 ± line 37)	606,777	3,659,354		38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	606,777	3,659,354		40.00
41.00	Interim payments	145,743	916,258		41.00
42.00	Balance due provider/program (line 40 minus 41)	461,034	2,743,096		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0		43.00

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

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G

Date/Time Prepared:  
2/15/2013 10:38 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	3,262,371	0	0	0	1.00
2.00	Temporary investments	11,486,062	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,170,746	0	0	0	4.00
5.00	Other receivable	2,645,793	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	384,691	0	0	0	7.00
8.00	Prepaid expenses	1	0	0	0	8.00
9.00	Other current assets	426,201	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)	23,375,865	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	588,318	0	0	0	12.00
13.00	Land improvements	854,467	0	0	0	13.00
14.00	Accumulated depreciation	-356,508	0	0	0	14.00
15.00	Buildings	20,101,220	0	0	0	15.00
16.00	Accumulated depreciation	-4,382,150	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	9,550,462	0	0	0	19.00
20.00	Accumulated depreciation	-2,416,987	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	12,923,930	0	0	0	23.00
24.00	Accumulated depreciation	-9,494,135	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)	27,368,617	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	11,730,680	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	749,221	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,479,901	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	63,224,383	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,308,114	0	0	0	37.00
38.00	Salaries, wages, and fees payable	787,355	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	920,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,091,769	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,107,238	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	27,305,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	27,305,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	33,412,238	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	29,812,145				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)	29,812,145	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	63,224,383	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-1

Date/Time Prepared:  
2/15/2013 10:38 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		26,323,394	
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,995,820			2.00
3.00	Total (sum of line 1 and line 2)		28,319,214		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	INCREASE IN RESTRICTED NET ASSETS	347		0		5.00
6.00	CHANGE IN UNREALIZED GAIN/LOSS	1,492,584		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)		1,492,931		0	10.00
11.00	Subtotal (line 3 plus line 10)		29,812,145		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)		29,812,145		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-1

Date/Time Prepared:  
2/15/2013 10:38 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/15/2013 10:38 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	2,640,364		2,640,364	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	326,613		326,613	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)	2,966,977		2,966,977	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	372,914		372,914	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	372,914		372,914	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,339,891		3,339,891	17.00
18.00	Ancillary services	4,572,119	41,528,141	46,100,260	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,002,806	2,002,806	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	DIETARY	802	7,308	8,110	27.00
27.01	NURSERY	0	0	0	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,912,812	43,538,255	51,451,067	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,240,353		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	2,638,533			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		2,638,533		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	GAIN ON DISPOSAL OF ASSETS	0			38.00
39.00	ROUNDING	0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,878,886		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141325

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-3

Date/Time Prepared:  
2/15/2013 10:38 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,451,067	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,844,445	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,606,622	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,878,886	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-272,264	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	744,809	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	13,849	24.00
24.01	OTHER REVENUE	1,512,249	24.01
24.02	CHANGE IN UNREALIZED GAINS	0	24.02
25.00	Total other income (sum of lines 6-24)	2,270,907	25.00
26.00	Total (line 5 plus line 25)	1,998,643	26.00
27.00	LOSS ON DISPOSAL OF EQUIPMENT	2,823	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,823	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,995,820	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2011 To 09/30/2012	Worksheet M-1 Date/Time Prepared: 2/15/2013 10:38 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	566,548	0	566,548	-174,437	392,111	1.00
2.00	Physician Assistant	264,820	0	264,820	0	264,820	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	425,424	0	425,424	0	425,424	9.00
10.00	Subtotal (sum of lines 1-9)	1,256,792	0	1,256,792	-174,437	1,082,355	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	14,907	14,907	0	14,907	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	46,198	46,198	-1,900	44,298	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	61,105	61,105	-1,900	59,205	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,256,792	61,105	1,317,897	-176,337	1,141,560	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
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
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,256,792	61,105	1,317,897	-176,337	1,141,560	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2011 To 09/30/2012	Worksheet M-1 Date/Time Prepared: 2/15/2013 10:38 am
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>			
1.00	Physician	0	392,111
2.00	Physician Assistant	0	264,820
3.00	Nurse Practitioner	0	0
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	425,424
10.00	Subtotal (sum of lines 1-9)	0	1,082,355
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	14,907
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	44,298
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	59,205
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,141,560
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>			
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
<b>FACILITY OVERHEAD</b>			
29.00	Facility Costs	0	0
30.00	Administrative Costs	0	0
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,141,560

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2011 To 09/30/2012	Worksheet M-2 Date/Time Prepared: 2/15/2013 10:38 am
			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	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	1.18	4,595	4,200	4,956	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.75	7,059	2,100	5,775	3.00
4.00	Subtotal (sum of lines 1-3)	3.93	11,654		10,731	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)	3.93	11,654			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)		1,141,560
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)		0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		1,141,560
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)		0
15.00	Parent provider overhead allocated to facility (see instructions)		1,296,756
16.00	Total overhead (sum of lines 14 and 15)		1,296,756
17.00	Allowable GME overhead (see instructions)		0
18.00	Subtract line 17 from line 16		1,296,756
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		1,296,756
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		2,438,316

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141325	Period: From 10/01/2011 To 09/30/2012	Worksheet M-3
		Component CCN: 143445		Date/Time Prepared: 2/15/2013 10:38 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
<b>DETERMINATION OF RATE FOR RHC/FQHC SERVICES</b>				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		2,438,316	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,438,316	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		11,654	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)		11,654	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		209.23	7.00
		<b>Calculation of Limit (1)</b>		
		<b>Prior to January 1</b>	<b>On or After January 1</b>	
		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)	209.23	209.23	9.00
<b>CALCULATION OF SETTLEMENT</b>				
10.00	Program covered visits excluding mental health services (from contractor records)	305	914	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	63,815	191,236	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	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		255,051	16.00
16.01	Total program charges (see instructions)(from contractor's records)		151,842	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,542	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		19,387	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.)		177,896	16.04
16.05	Total program cost (see instructions)		197,283	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,294	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		25,401	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		197,283	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		197,283	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)		197,283	26.00
27.00	Interim payments		206,937	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)		-9,654	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		3,910	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2011 To 09/30/2012	Worksheet M-5 Date/Time Prepared: 2/15/2013 10:38 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		194,014	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		05/18/2012	3,599	3.01
3.02		09/21/2012	9,324	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)		12,923	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		206,937	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		9,654	6.02
7.00	Total Medicare program liability (see instructions)		197,283	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00