

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: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/29/2012 8:45 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/29/2012 Time: 8:45 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	129,409	242	0	0	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	37,584	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		-4,777		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	166,993	-4,535	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 7:51 am
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
1.00 Street: 2100 STATE STREET		PO Box: 62439		1.00	
2.00 City: LAWRENCEVILLE		State: IL		2.00 Zip Code: 62439- County: LAWRENCE	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
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	LAWRENCE COUNTY MEMORIAL HOSPITAL	141344	99914	1	04/01/2005	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	LAWRENCE COUNTY MEMORIAL HOSPITAL	14Z344	99914		04/01/2005	N	0	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	LCMH PRIMARY CARE CLINIC	143499	99914		03/26/2009	N	0	N	15.00
16.00	Hospital-Based Health Clinic - FOHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1						N	N	N	17.00
17.10	Hospital-Based (CORF) 1									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)	07/01/2011	06/30/2012	20.00
21.00	Type of Control (see instructions)	2		21.00

22.00		Inpatient PPS Information				
Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.		N	N	22.00		
23.00		Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.		2	N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	0	0	0	0	0	0	24.00
If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							
25.00	0	0	0	0	0	0	25.00
If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid eligible days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.							

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	2		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/29/2012 7:51 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141344

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

Worksheet S-2
Part I
Date/Time Prepared:
11/29/2012 7:51 am

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

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		1.00	2.00	3.00			
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00	
				1.00			
Long Term Care Hospital PPS							
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)			N		80.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00	
				V	XIX		
				1.00	2.00		
Title V or XIX Inpatient Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y				108.00	
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	Y	N		109.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	

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			1.00	2.00	3.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00
			Premiums	Losses	Insurance
			1.00	2.00	3.00
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	143,861	0	0	118.01
			1.00	2.00	
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
			1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:		
142.00	Street:	PO Box:			
143.00	City:	State:	Zip Code:		
			1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141344

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

Worksheet S-2
Part I
Date/Time Prepared:
11/29/2012 7:51 am

		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
					1.00		
Multi-campus							
165.00	Is this hospital part of a Multi-campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
					1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/29/2012 7:51 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)	Y	07/01/2011	1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	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	09/24/2012	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: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/29/2012 7:51 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.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions	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.	Y		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANDREW	RINZEL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173833682	ARINZEL@BKD.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	09/24/2012	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		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		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: 141344

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	72,744.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	72,744.00		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)		25	9,150	72,744.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	0	0			16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY						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	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF	40.00					28.01
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141344

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 7:51 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	1,716	214	2,204		1.00
2.00 HMO		9	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	791	0	791		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	36		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,507	214	3,031		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	2,507	214	3,031		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	0	0	0		16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						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	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	2,446	4,152	9,709		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		1	8		28.00
28.01 SUBPROVIDER - IPF				0		28.01
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				5		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: 141344

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 7:51 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	466	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	119.51	0.00	0	466	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0.00	0.00	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						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	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	10.06	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	129.57	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141344

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2012 7:51 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)	78	669		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	78	669		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	0	0		16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.01 SUBPROVIDER - IPF				28.01
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141344 Component CCN: 143499		Period: From 07/01/2011 To 06/30/2012		Worksheet S-8 Date/Time Prepared: 11/29/2012 7:51 am	
				Rural Health Clinic (RHC) I		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		2111 LEXINGTON AVENUE				1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		LAWRENCEVILLE		IL		62439 2.00	
3.00							
FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
0 3.00							
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
10.00							
Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0 10.00	
				Sunday		Monday	
		from to		from to			
		1.00 2.00		3.00 4.00			
11.00 Facility hours of operations (1)							
11.00 Clinic				08:00		17:00 11.00	
12.00							
Have you received an approval for an exception to the productivity standard?				N		12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00 Provider name, CCN number							
		Y/N		V		XVIII	
		1.00		2.00		3.00	
				XIX		Total Visits	
				4.00		5.00	
15.00		Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable, and the total number of visits in column 5. (see instructions)		0		0 15.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/29/2012 7:51 am
			Rural Health Clinic (RHC) I	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County			2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/29/2012 7:51 am		
			Rural Health Clinic (RHC) I	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/29/2012 7:51 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: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet S-10 Date/Time Prepared: 11/29/2012 7:51 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.463155	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,201,350	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		482,055	5.00	
6.00	Medicaid charges		5,526,413	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,559,586	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)		876,181	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		876,181	19.00	
			1.00		
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	893,995	644,216	1,538,211	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	414,058	298,372	712,430	21.00
22.00	Partial payment by patients approved for charity care	67,922	500,688	568,610	22.00
23.00	Cost of charity care (line 21 minus line 22)	346,136	-202,316	143,820	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)		1,175,597	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		226,488	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		949,109	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		439,585	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		583,405	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,459,586	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141344

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

Worksheet A
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		262,571		262,571	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		335,602		335,602	2.00
4.00	00400	EMPLOYEE BENEFITS	0	1,438,395		1,438,395	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	283,848	289,954		573,802	5.01
5.02	00511	PURCHASING, RECEIVING AND STORES	63,427	-1,920		61,507	5.02
5.03	00512	COMMUNICATIONS	0	55,095		55,095	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	221,160	1,183,303		1,404,463	5.04
6.00	00600	MAINTENANCE & REPAIRS	157,285	96,633		253,918	6.00
7.00	00700	OPERATION OF PLANT	0	106,401		106,401	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,729		48,729	8.00
9.00	00900	HOUSEKEEPING	171,106	29,487		200,593	9.00
10.00	01000	DIETARY	205,104	177,592		382,696	10.00
11.00	01100	CAFETERIA	0	0		281,711	11.00
13.00	01300	NURSING ADMINISTRATION	173,191	42,797		215,988	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		0	14.00
15.00	01500	PHARMACY	162,248	19,657		181,905	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	231,943	47,177		279,120	16.00
17.00	01700	SOCIAL SERVICE	65,005	847		65,852	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	4,134		4,134	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	837,857	47,655		885,512	30.00
40.00	04000	SUBPROVIDER - IPF	0	0		0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0		0	41.00
42.00	04200	SUBPROVIDER	0	0		0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	165,725	132,202		297,927	50.00
53.00	05300	ANESTHESIOLOGY	0	290,275		290,275	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,517	685,609		908,126	54.00
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	440,389	370,195		810,584	60.00
60.01	06001	BLOOD LABORATORY	0	0		0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	50,043		50,043	62.00
65.00	06500	RESPIRATORY THERAPY	145,270	23,260		168,530	65.00
66.00	06600	PHYSICAL THERAPY	112,257	7,566		119,823	66.00
66.01	06601	CARDIAC REHAB	12,967	1,312		14,279	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,376		32,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	182,843		182,843	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	38,908	6,175		45,083	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	395,453	455,769		851,222	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	89.00
90.00	09000	CLINIC	63,853	302,081		365,934	90.00
91.00	09100	EMERGENCY	386,506	1,009,493		1,395,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	92.00
93.00	04040	FAMILY PRACTICE	0	0		0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0		0	95.00
99.10	09910	CORF	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS							
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
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,556,019	7,733,308		12,289,327	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,695		20,695	192.00
192.01	19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0		0	192.01
192.02	19202	LSC	0	0		0	192.02
192.03	19203	PUBLIC RELATIONS	0	0		0	192.03
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	4,556,019	7,754,003		12,310,022	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141344

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

Worksheet A
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	262,571	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-7,253	328,349	2.00
4.00	00400	EMPLOYEE BENEFITS	-567	1,469,087	4.00
5.01	00510	ADMINISTRATIVE & GENERAL	-29,656	544,146	5.01
5.02	00511	PURCHASING, RECEIVING AND STORES	-23,583	37,924	5.02
5.03	00512	COMMUNICATIONS	0	55,095	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	-81,326	1,291,878	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	253,918	6.00
7.00	00700	OPERATION OF PLANT	0	106,401	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,729	8.00
9.00	00900	HOUSEKEEPING	0	200,593	9.00
10.00	01000	DIETARY	0	100,985	10.00
11.00	01100	CAFETERIA	-65,989	215,722	11.00
13.00	01300	NURSING ADMINISTRATION	0	215,988	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	181,905	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,393	272,727	16.00
17.00	01700	SOCIAL SERVICE	0	93,958	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	4,134	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	885,512	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	297,927	50.00
53.00	05300	ANESTHESIOLOGY	-263,122	27,153	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	908,126	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	810,584	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	50,043	62.00
65.00	06500	RESPIRATORY THERAPY	-622	167,908	65.00
66.00	06600	PHYSICAL THERAPY	0	119,823	66.00
66.01	06601	CARDIAC REHAB	-200	14,079	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	32,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	182,843	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	-4,980	11,997	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-28,161	833,430	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-278,203	87,731	90.00
91.00	09100	EMERGENCY	-196,659	1,199,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
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
118.00		SUBTOTALS (SUM OF LINES 1-117)	-986,714	11,312,982	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,326	192.00
192.01	19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	192.01
192.02	19202	LSC	0	0	192.02
192.03	19203	PUBLIC RELATIONS	0	0	192.03
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-986,714	11,323,308	200.00

RECLASSIFICATIONS

Provider CCN: 141344

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

Worksheet A-6

Date/Time Prepared:
11/29/2012 7:51 am

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
A - CAFETERIA RECLASS						
1.00	CAFETERIA		11.00	151,130	130,581	1.00
	TOTALS			151,130	130,581	
B - EMPLOYEE BENEFIT RECLASS						
1.00	EMPLOYEE BENEFITS		4.00	31,259	0	1.00
	TOTALS			31,259	0	
C - RHC UTILITIES RECLASS						
1.00	RURAL HEALTH CLINIC		88.00	0	10,369	1.00
	TOTALS			0	10,369	
D - INFECTION CONTROL RECLASS						
1.00	SOCIAL SERVICE		17.00	28,106	0	1.00
	TOTALS			28,106	0	
500.00	Grand Total: Increases			210,495	140,950	500.00

RECLASSIFICATIONS

Provider CCN: 141344

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

Worksheet A-6
Date/Time Prepared:
11/29/2012 7:51 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	151,130	130,581	0		1.00
	TOTALS		151,130	130,581			
B - EMPLOYEE BENEFIT RECLASS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	31,259	0	0		1.00
	TOTALS		31,259	0			
C - RHC UTILITIES RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	10,369	0		1.00
	TOTALS		0	10,369			
D - INFECTION CONTROL RECLASS							
1.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00	28,106	0	0		1.00
	TOTALS		28,106	0			
500.00	Grand Total: Decreases		210,495	140,950			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141344

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2012 7:51 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	20,150	0	0	0	0	1.00
2.00	Land Improvements	353,171	0	0	0	0	2.00
3.00	Buildings and Fixtures	5,247,805	250,941	0	250,941	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	497,869	0	0	0	0	5.00
6.00	Movable Equipment	4,497,697	352,654	0	352,654	9,325	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,616,692	603,595	0	603,595	9,325	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	10,616,692	603,595	0	603,595	9,325	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	209,234	0	0	33,940	19,397	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	302,868	0	32,734	0	0	2.00
3.00	Total (sum of lines 1-2)	512,102	0	32,734	33,940	19,397	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	6,369,936	0	6,369,936	0.568188	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,841,026	0	4,841,026	0.431812	0	2.00
3.00	Total (sum of lines 1-2)	11,210,962	0	11,210,962	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141344

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2012 7:51 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	20,150	0		1.00		
2.00	Land Improvements	353,171	0		2.00		
3.00	Buildings and Fixtures	5,498,746	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	497,869	0		5.00		
6.00	Movable Equipment	4,841,026	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	11,210,962	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	11,210,962	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	262,571		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	335,602		2.00		
3.00	Total (sum of lines 1-2)	0	598,173		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	209,234	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	302,868	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	512,102	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141344

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	33,940	19,397	0	262,571	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	25,481	0	0	0	328,349	2.00
3.00	Total (sum of lines 1-2)	25,481	33,940	19,397	0	590,920	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141344

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

Worksheet A-8

Date/Time Prepared:
11/29/2012 7:51 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)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-7,133	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)		0	0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-23,583	0	PURCHASING, RECEIVING AND STORES	5.02 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	0		0.00 7.00
8.00 Television and radio service (chapter 21)		0	0		0.00 8.00
9.00 Parking lot (chapter 21)		0	0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-433,218	0		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0	0		12.00
13.00 Laundry and linen service		0	0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-65,989	0	CAFETERIA	11.00 14.00
15.00 Rental of quarters to employee and others		0	0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-6,393	0	MEDICAL RECORDS & LIBRARY	16.00 16.00
17.00 Sale of drugs to other than patients		0	0		0.00 17.00
18.00 Sale of medical records and abstracts		0	0		0.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	0		0.00 19.00
20.00 Vending machines		0	0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist		0	0	NONPHYSICIAN ANESTHETISTS	19.00 28.00
29.00 Physicians' assistant		0	0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0	0		0.00 32.00
33.00 PHYSICIAN MALPRACTICE COSTS	A	-19,292	0	EMERGENCY	91.00 33.00
34.00 MISC EXPENSE - ADMIN	A	-10,508	0	OTHER ADMINISTRATIVE AND GENERAL	5.04 34.00
35.00 DONATIONS EXPENSE	A	-9,293	0	OTHER ADMINISTRATIVE AND GENERAL	5.04 35.00
36.00 MISC REVENUE - ADMIN	B	-4,342	0	OTHER ADMINISTRATIVE AND GENERAL	5.04 36.00
37.00 PHYSICIAN RECRUITMENT	A	-25,929	0	OTHER ADMINISTRATIVE AND GENERAL	5.04 37.00
38.00 TELEPHONE OFFSET	A	-120	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 38.00
39.00 TELEPHONE OFFSET	A	-2,087	0	OTHER ADMINISTRATIVE AND GENERAL	5.04 39.00
40.00 TELEPHONE OFFSET	A	-567	0	EMPLOYEE BENEFITS	4.00 40.00
41.00 LOBBYING EXPENSE	A	-4,879	0	OTHER ADMINISTRATIVE AND GENERAL	5.04 41.00
42.00 PART B PHYSICIAN BILLING COSTS	A	-29,656	0	ADMINISTRATIVE & GENERAL	5.01 42.00
43.00 ADVERTISING - ADMIN	A	-24,288	0	OTHER ADMINISTRATIVE AND GENERAL	5.04 43.00
44.00 PHYSICIAN COST OFFSET	A	-278,203	0	CLINIC	90.00 44.00

Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8 Date/Time Prepared: 11/29/2012 7:51 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	
45.00 ANESTHESIA BENEFITS	A	-13,073	ANESTHESIOLOGY	53.00	45.00
46.00 COST OF RHC DOCS IN HOSPITAL	A	-28,161	RURAL HEALTH CLINIC	88.00	46.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-986,714			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141344

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

Worksheet A-8

Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	11	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	PHYSICIAN MALPRACTICE COSTS	0	33.00
34.00	MISC EXPENSE - ADMIN	0	34.00
35.00	DONATIONS EXPENSE	0	35.00
36.00	MISC REVENUE - ADMIN	0	36.00
37.00	PHYSICIAN RECRUITMENT	0	37.00
38.00	TELEPHONE OFFSET	11	38.00
39.00	TELEPHONE OFFSET	0	39.00
40.00	TELEPHONE OFFSET	0	40.00
41.00	LOBBYING EXPENSE	0	41.00
42.00	PART B PHYSICIAN BILLING COSTRS	0	42.00
43.00	ADVERTISING - ADMIN	0	43.00
44.00	PHYSICIAN COST OFFSET	0	44.00
45.00	ANESTHESIA BENEFITS	0	45.00
46.00	COST OF RHC DOCS IN HOSPITAL	0	46.00
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: 141344

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 7:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	66.01	CARDIAC REHAB	200	200	1.00
2.00	53.00	ANESTHESIOLOGY	250,049	250,049	2.00
3.00	91.00	EMERGENCY	955,679	177,367	3.00
4.00	65.00	RESPIRATORY THERAPY	622	622	4.00
5.00	76.00	OTHER ANCILLARY SERVICE COST CENTERS	4,980	4,980	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,211,530	433,218	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141344

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 7:51 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	0	0	0	0	0	2.00
3.00	778,312	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	778,312			0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141344

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2012 7:51 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141344

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

Worksheet A-8-2
Date/Time Prepared:
11/29/2012 7:51 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	200	1.00
2.00	0	250,049	2.00
3.00	0	177,367	3.00
4.00	0	622	4.00
5.00	0	4,980	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	433,218	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141344		Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2012 7:51 am	
		Physical Therapy		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.39	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.19	37.19	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					149	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					149	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					149	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					74.50	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					58,110	22.00
23.00	Total salary equivalency (see instructions)					58,110	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141344				Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2012 7:51 am	
		Physical Therapy				Cost			
						1.00			
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.39	0.00	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					58,110		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					58,110		63.00	
64.00	Total cost of outside supplier services (from your records)					105		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					0		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					0		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141344		Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2012 7:51 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	65.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.74	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.87	33.87	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					4,403	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					4,403	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					4,403	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					67.74	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,837	22.00
23.00	Total salary equivalency (see instructions)					52,837	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141344				Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/29/2012 7:51 am	
						Speech Pathology		Cost	
								1.00	
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								0 46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.74	0.00	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
								1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							52,837	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							52,837	63.00
64.00	Total cost of outside supplier services (from your records)							4,926	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							0	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							0	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141344

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

Worksheet B
Part I
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	262,571	262,571				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	328,349		328,349			2.00
4.00 00400 EMPLOYEE BENEFITS	1,469,087	0	0	1,469,087		4.00
5.01 00510 ADMINISTRATIVE & GENERAL	544,146	8,648	1,758	92,159	646,711	5.01
5.02 00511 PURCHASING, RECEIVING AND STORES	37,924	2,385	0	20,593	0	5.02
5.03 00512 COMMUNICATIONS	55,095	0	0	0	0	5.03
5.04 00560 OTHER ADMINISTRATIVE AND GENERAL	1,291,878	20,481	20,044	61,656	0	5.04
6.00 00600 MAINTENANCE & REPAIRS	253,918	0	0	51,067	0	6.00
7.00 00700 OPERATION OF PLANT	106,401	59,030	4,666	0	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	48,729	0	0	0	0	8.00
9.00 00900 HOUSEKEEPING	200,593	3,410	0	55,554	0	9.00
10.00 01000 DIETARY	100,985	4,153	631	17,524	0	10.00
11.00 01100 CAFETERIA	215,722	8,648	1,894	49,068	0	11.00
13.00 01300 NURSING ADMINISTRATION	215,988	1,018	0	56,231	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 01500 PHARMACY	181,905	1,772	0	52,678	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	272,727	5,896	3,016	75,307	0	16.00
17.00 01700 SOCIAL SERVICE	93,958	210	0	30,231	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	4,134	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	885,512	27,052	29,993	272,036	45,665	30.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	297,927	23,605	25,187	53,807	53,968	50.00
53.00 05300 ANESTHESIOLOGY	27,153	511	3,712	0	8,059	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	908,126	9,816	117,386	72,246	170,191	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	810,584	4,318	11,501	142,984	140,984	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	50,043	1,051	0	0	6,873	62.00
65.00 06500 RESPIRATORY THERAPY	167,908	3,368	704	47,166	21,645	65.00
66.00 06600 PHYSICAL THERAPY	119,823	4,435	522	36,447	11,291	66.00
66.01 06601 CARDIAC REHAB	14,079	1,802	11,406	4,210	1,298	66.01
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32,376	2,122	0	0	22,143	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	182,843	0	118	0	50,060	73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	11,997	0	0	3,507	635	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	833,430	29,084	44,706	128,394	29,081	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	87,731	9,279	14,613	20,732	3,388	90.00
91.00 09100 EMERGENCY	1,199,340	8,945	4,855	125,490	81,430	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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
118.00 SUBTOTALS (SUM OF LINES 1-117)	11,312,982	241,039	296,712	1,469,087	646,711	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	10,326	21,532	31,637	0	0	192.00
192.01 19201 RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02 19202 LSC	0	0	0	0	0	192.02
192.03 19203 PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	11,323,308	262,571	328,349	1,469,087	646,711	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 141344		Period: From 07/01/2011 To 06/30/2012		Worksheet B Part I Date/Time Prepared: 11/29/2012 7:51 am	
Cost Center Description			PURCHASING, RECEIVING AND STORES	COMMUNICATIONS	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMINISTRATIVE & GENERAL						5.01
5.02	00511	PURCHASING, RECEIVING AND STORES	60,902					5.02
5.03	00512	COMMUNICATIONS	0	55,095				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	3,413	6,611	1,404,083	1,404,083		5.04
6.00	00600	MAINTENANCE & REPAIRS	1,951	0	306,936	43,447	350,383	6.00
7.00	00700	OPERATION OF PLANT	171	3,673	173,941	24,622	89,517	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	48,729	6,898	0	8.00
9.00	00900	HOUSEKEEPING	3,429	367	263,353	37,278	5,171	9.00
10.00	01000	DIETARY	1,282	1,469	126,044	17,842	6,298	10.00
11.00	01100	CAFETERIA	3,845	0	279,177	39,518	13,114	11.00
13.00	01300	NURSING ADMINISTRATION	3,960	2,938	280,135	39,654	1,543	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	485	0	236,840	33,525	2,688	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	465	5,142	362,553	51,320	8,940	16.00
17.00	01700	SOCIAL SERVICE	100	735	125,234	17,727	319	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	4,134	585	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,304	10,284	1,275,846	180,599	41,023	30.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,690	2,938	466,122	65,981	35,795	50.00
53.00	05300	ANESTHESIOLOGY	795	367	40,597	5,747	774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,409	2,204	1,286,378	182,089	14,885	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	8,105	1,837	1,120,313	158,583	6,549	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,700	0	59,667	8,446	1,594	62.00
65.00	06500	RESPIRATORY THERAPY	799	1,837	243,427	34,458	5,108	65.00
66.00	06600	PHYSICAL THERAPY	151	1,102	173,771	24,598	6,725	66.00
66.01	06601	CARDIAC REHAB	89	735	33,619	4,759	2,733	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,827	0	60,468	8,559	3,217	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	735	233,756	33,089	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	54	0	16,193	2,292	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,707	6,979	1,073,381	151,939	44,103	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	529	2,204	138,476	19,602	14,071	90.00
91.00	09100	EMERGENCY	3,496	2,938	1,426,494	201,917	13,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
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
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,756	55,095	11,259,667	1,395,074	317,731	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	146	0	63,641	9,009	32,652	192.00
192.01	19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	19202	LSC	0	0	0	0	0	192.02
192.03	19203	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	60,902	55,095	11,323,308	1,404,083	350,383	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141344

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

Worksheet B
Part I
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	ADMINISTRATIVE & GENERAL					5.01
5.02	00511	PURCHASING, RECEIVING AND STORES					5.02
5.03	00512	COMMUNICATIONS					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	288,080				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	55,627			8.00
9.00	00900	HOUSEKEEPING	8,234	0	314,036		9.00
10.00	01000	DIETARY	10,030	567	10,410	171,191	10.00
11.00	01100	CAFETERIA	20,885	0	31,265	0	383,959
13.00	01300	NURSING ADMINISTRATION	2,458	0	946	0	11,300
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	4,280	0	710	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	14,238	0	3,819	0	34,885
17.00	01700	SOCIAL SERVICE	508	0	0	0	8,430
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,330	35,204	75,275	171,191	95,508
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	57,005	6,265	30,758	0	20,178
53.00	05300	ANESTHESIOLOGY	1,233	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,705	4,363	11,661	0	30,087
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	10,429	0	9,734	0	47,933
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,539	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	8,134	137	3,481	0	23,137
66.00	06600	PHYSICAL THERAPY	10,710	1,244	7,808	0	7,533
66.01	06601	CARDIAC REHAB	4,353	0	3,515	0	762
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,461
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	1,121
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	32,245	0	45,108
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	22,408	6	19,536	0	8,699
91.00	09100	EMERGENCY	21,601	7,841	35,287	0	39,817
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
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
118.00		SUBTOTALS (SUM OF LINES 1-117)	288,080	55,627	276,450	171,191	383,959
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	37,586	0	0
192.01	19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	0	0	0
192.02	19202	LSC	0	0	0	0	0
192.03	19203	PUBLIC RELATIONS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	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)	288,080	55,627	314,036	171,191	383,959

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141344

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

Worksheet B
Part I
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00560						5.04
6.00	00600						6.00
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	336,036					13.00
14.00	01400	0	0				14.00
15.00	01500	0	0	278,043			15.00
16.00	01600	0	0	0	475,755		16.00
17.00	01700	0	0	0	0	152,218	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	196,869	0	0	182,462	152,218	30.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	41,595	0	0	26,371	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	0	0	62.00
65.00	06500	0	0	0	17,819	0	65.00
66.00	06600	15,506	0	0	0	0	66.00
66.01	06601	0	0	0	0	0	66.01
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	278,043	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	10,691	0	90.00
91.00	09100	82,066	0	0	237,343	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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
118.00		336,036	0	278,043	474,686	152,218	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	1,069	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		336,036	0	278,043	475,755	152,218	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141344

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

Worksheet B
Part I
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	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
5.01	00510	ADMINISTRATIVE & GENERAL				5.01
5.02	00511	PURCHASING, RECEIVING AND STORES				5.02
5.03	00512	COMMUNICATIONS				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00	00600	MAINTENANCE & REPAIRS				6.00
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				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	4,719			19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,471,525	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	750,070	0	50.00
53.00	05300	ANESTHESIOLOGY	4,719	53,070	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,553,168	0	54.00
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	1,353,541	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	72,246	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	335,701	0	65.00
66.00	06600	PHYSICAL THERAPY	0	247,895	0	66.00
66.01	06601	CARDIAC REHAB	0	49,741	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	72,244	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	554,349	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	19,606	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,346,776	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	233,489	0	90.00
91.00	09100	EMERGENCY	0	2,065,930	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,719	11,179,351	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	143,957	0	192.00
192.01	19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	0	192.01
192.02	19202	LSC	0	0	0	192.02
192.03	19203	PUBLIC RELATIONS	0	0	0	192.03
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,719	11,323,308	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141344

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

Worksheet B
Part II
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2. 00			
GENERAL SERVICE COST CENTERS						
1. 00	00100	NEW CAP REL COSTS-BLDG & FIXT				1. 00
2. 00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2. 00
4. 00	00400	EMPLOYEE BENEFITS	0	0	0	4. 00
5. 01	00510	ADMINISTRATIVE & GENERAL	0	8,648	1,758	5. 01
5. 02	00511	PURCHASING, RECEIVING AND STORES	0	2,385	0	5. 02
5. 03	00512	COMMUNICATIONS	0	0	0	5. 03
5. 04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	20,481	20,044	5. 04
6. 00	00600	MAINTENANCE & REPAIRS	0	0	0	6. 00
7. 00	00700	OPERATION OF PLANT	0	59,030	4,666	7. 00
8. 00	00800	LAUNDRY & LINEN SERVICE	0	0	0	8. 00
9. 00	00900	HOUSEKEEPING	0	3,410	0	9. 00
10. 00	01000	DIETARY	0	4,153	631	10. 00
11. 00	01100	CAFETERIA	0	8,648	1,894	11. 00
13. 00	01300	NURSING ADMINISTRATION	0	1,018	0	13. 00
14. 00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	14. 00
15. 00	01500	PHARMACY	0	1,772	0	15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	0	5,896	3,016	16. 00
17. 00	01700	SOCIAL SERVICE	0	210	0	17. 00
19. 00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000	ADULTS & PEDIATRICS	0	27,052	29,993	30. 00
40. 00	04000	SUBPROVIDER - I PF	0	0	0	40. 00
41. 00	04100	SUBPROVIDER - I RF	0	0	0	41. 00
42. 00	04200	SUBPROVIDER	0	0	0	42. 00
ANCILLARY SERVICE COST CENTERS						
50. 00	05000	OPERATING ROOM	0	23,605	25,187	50. 00
53. 00	05300	ANESTHESIOLOGY	0	511	3,712	53. 00
54. 00	05400	RADIOLOGY-DIAGNOSTIC	0	9,816	117,386	54. 00
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	4,318	11,501	60. 00
60. 01	06001	BLOOD LABORATORY	0	0	0	60. 01
62. 00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,051	0	62. 00
65. 00	06500	RESPIRATORY THERAPY	0	3,368	704	65. 00
66. 00	06600	PHYSICAL THERAPY	0	4,435	522	66. 00
66. 01	06601	CARDIAC REHAB	0	1,802	11,406	66. 01
69. 00	06900	ELECTROCARDIOLOGY	0	0	0	69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,122	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	118	73. 00
76. 00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00	08800	RURAL HEALTH CLINIC	0	29,084	44,706	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89. 00
90. 00	09000	CLINIC	0	9,279	14,613	90. 00
91. 00	09100	EMERGENCY	0	8,945	4,855	91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92. 00
93. 00	04040	FAMILY PRACTICE	0	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00	09500	AMBULANCE SERVICES	0	0	0	95. 00
99. 10	09910	CORF	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS						
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
118. 00		SUBTOTALS (SUM OF LINES 1-117)	0	241,039	296,712	118. 00
NONREIMBURSABLE COST CENTERS						
190. 00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190. 00
192. 00	19200	PHYSICIANS' PRIVATE OFFICES	0	21,532	31,637	192. 00
192. 01	19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	0	192. 01
192. 02	19202	LSC	0	0	0	192. 02
192. 03	19203	PUBLIC RELATIONS	0	0	0	192. 03
194. 00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194. 00
200. 00		Cross Foot Adjustments			0	200. 00
201. 00		Negative Cost Centers		0	0	201. 00
202. 00		TOTAL (sum lines 118-201)	0	262,571	328,349	202. 00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141344		Period: From 07/01/2011 To 06/30/2012		Worksheet B Part II Date/Time Prepared: 11/29/2012 7:51 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	PURCHASING, RECEIVING AND STORES	COMMUNICATIONS	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	ADMINISTRATIVE & GENERAL	10,406				5.01
5.02	00511	PURCHASING, RECEIVING AND STORES	0	2,385			5.02
5.03	00512	COMMUNICATIONS	0	0	0		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	134	0	40,659	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	76	0	1,258	6.00
7.00	00700	OPERATION OF PLANT	0	7	0	713	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	200	8.00
9.00	00900	HOUSEKEEPING	0	134	0	1,079	9.00
10.00	01000	DIETARY	0	50	0	517	10.00
11.00	01100	CAFETERIA	0	151	0	1,144	11.00
13.00	01300	NURSING ADMINISTRATION	0	155	0	1,148	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	19	0	971	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18	0	1,486	16.00
17.00	01700	SOCIAL SERVICE	0	4	0	513	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	17	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	735	208	0	5,230	30.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	869	340	0	1,911	50.00
53.00	05300	ANESTHESIOLOGY	130	31	0	166	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,735	251	0	5,273	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,269	317	0	4,592	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	111	67	0	245	62.00
65.00	06500	RESPIRATORY THERAPY	348	31	0	998	65.00
66.00	06600	PHYSICAL THERAPY	182	6	0	712	66.00
66.01	06601	CARDIAC REHAB	21	3	0	138	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	356	150	0	248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	806	0	0	958	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	10	2	0	66	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	468	67	0	4,400	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	55	21	0	568	90.00
91.00	09100	EMERGENCY	1,311	137	0	5,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,406	2,379	0	40,398	1,210
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6	0	261	192.00
192.01	19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	0	0	192.01
192.02	19202	LSC	0	0	0	0	192.02
192.03	19203	PUBLIC RELATIONS	0	0	0	0	192.03
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,406	2,385	0	40,659	1,334

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/29/2012 7:51 am
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	ADMINISTRATIVE & GENERAL					5.01
5.02	00511	PURCHASING, RECEIVING AND STORES					5.02
5.03	00512	COMMUNICATIONS					5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	64,757				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	200			8.00
9.00	00900	HOUSEKEEPING	1,851	0	6,494		9.00
10.00	01000	DIETARY	2,255	2	215	7,847	10.00
11.00	01100	CAFETERIA	4,695	0	647	0	17,229
13.00	01300	NURSING ADMINISTRATION	552	0	20	0	507
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	962	0	15	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	3,200	0	79	0	1,565
17.00	01700	SOCIAL SERVICE	114	0	0	0	378
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,686	127	1,556	7,847	4,287
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,814	23	636	0	905
53.00	05300	ANESTHESIOLOGY	277	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,329	16	241	0	1,350
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,344	0	201	0	2,151
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	571	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,829	0	72	0	1,038
66.00	06600	PHYSICAL THERAPY	2,407	4	161	0	338
66.01	06601	CARDIAC REHAB	978	0	73	0	34
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	425
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	50
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	667	0	2,024
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	5,037	0	404	0	390
91.00	09100	EMERGENCY	4,856	28	730	0	1,787
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
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
118.00		SUBTOTALS (SUM OF LINES 1-117)	64,757	200	5,717	7,847	17,229
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	777	0	0
192.01	19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	0	0	0
192.02	19202	LSC	0	0	0	0	0
192.03	19203	PUBLIC RELATIONS	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	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)	64,757	200	6,494	7,847	17,229

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141344

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

Worksheet B
Part II
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00560						5.04
6.00	00600						6.00
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	3,406					13.00
14.00	01400	0	0				14.00
15.00	01500	0	0	3,749			15.00
16.00	01600	0	0	0	15,294		16.00
17.00	01700	0	0	0	0	1,220	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,995	0	0	5,866	1,220	30.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	422	0	0	848	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	0	0	62.00
65.00	06500	0	0	0	573	0	65.00
66.00	06600	157	0	0	0	0	66.00
66.01	06601	0	0	0	0	0	66.01
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	3,749	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	344	0	90.00
91.00	09100	832	0	0	7,629	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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
118.00		3,406	0	3,749	15,260	1,220	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	34	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,406	0	3,749	15,294	1,220	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141344

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

Worksheet B
Part II
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	00510					5.01
5.02	00511					5.02
5.03	00512					5.03
5.04	00560					5.04
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700					17.00
19.00	01900	17				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000		100,958	0	100,958	30.00
40.00	04000		0	0	0	40.00
41.00	04100		0	0	0	41.00
42.00	04200		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000		67,696	0	67,696	50.00
53.00	05300		4,830	0	4,830	53.00
54.00	05400		142,454	0	142,454	54.00
57.00	05700		0	0	0	57.00
58.00	05800		0	0	0	58.00
59.00	05900		0	0	0	59.00
60.00	06000		27,718	0	27,718	60.00
60.01	06001		0	0	0	60.01
62.00	06200		2,051	0	2,051	62.00
65.00	06500		8,980	0	8,980	65.00
66.00	06600		8,950	0	8,950	66.00
66.01	06601		14,465	0	14,465	66.01
69.00	06900		0	0	0	69.00
71.00	07100		2,888	0	2,888	71.00
72.00	07200		0	0	0	72.00
73.00	07300		6,056	0	6,056	73.00
76.00	03020		128	0	128	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800		81,584	0	81,584	88.00
89.00	08900		0	0	0	89.00
90.00	09000		30,765	0	30,765	90.00
91.00	09100		37,009	0	37,009	91.00
92.00	09200		0	0	0	92.00
93.00	04040		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500		0	0	0	95.00
99.10	09910		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900		0	0	0	109.00
110.00	11000		0	0	0	110.00
111.00	11100		0	0	0	111.00
118.00		0	536,532	0	536,532	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000		0	0	0	190.00
192.00	19200		54,371	0	54,371	192.00
192.01	19201		0	0	0	192.01
192.02	19202		0	0	0	192.02
192.03	19203		0	0	0	192.03
194.00	07950		0	0	0	194.00
200.00		17	17	0	17	200.00
201.00		0	0	0	0	201.00
202.00		17	590,920	0	590,920	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141344

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

Worksheet B-1

Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (GROSS CHARGES)	PURCHASING, RECEIVING AND STORES (COSTED REQUIS.)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	69,923				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		406,849			2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	4,524,760		4.00
5.01 00510	ADMINISTRATIVE & GENERAL	2,303	2,178	283,848	24,151,587	5.01
5.02 00511	PURCHASING, RECEIVING AND STORES	635	0	63,427	0	515,262 5.02
5.03 00512	COMMUNICATIONS	0	0	0	0	0 5.03
5.04 00560	OTHER ADMINISTRATIVE AND GENERAL	5,454	24,836	189,901	0	28,875 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	157,285	0	16,506 6.00
7.00 00700	OPERATION OF PLANT	15,720	5,782	0	0	1,443 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	908	0	171,106	0	29,015 9.00
10.00 01000	DIETARY	1,106	782	53,974	0	10,845 10.00
11.00 01100	CAFETERIA	2,303	2,347	151,130	0	32,534 11.00
13.00 01300	NURSING ADMINISTRATION	271	0	173,191	0	33,506 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00 01500	PHARMACY	472	0	162,248	0	4,101 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,570	3,737	231,943	0	3,936 16.00
17.00 01700	SOCIAL SERVICE	56	0	93,111	0	847 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,204	37,163	837,857	1,705,376	44,874 30.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,286	31,208	165,725	2,015,473	73,522 50.00
53.00 05300	ANESTHESIOLOGY	136	4,599	0	300,961	6,723 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,614	145,451	222,517	6,355,666	54,222 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	1,150	14,250	440,389	5,265,132	68,569 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	280	0	0	256,690	14,383 62.00
65.00 06500	RESPIRATORY THERAPY	897	872	145,270	808,359	6,759 65.00
66.00 06600	PHYSICAL THERAPY	1,181	647	112,257	421,652	1,280 66.00
66.01 06601	CARDIAC REHAB	480	14,133	12,967	48,465	751 66.01
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	565	0	0	826,936	32,376 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	146	0	1,869,529	0 73.00
76.00 03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	10,802	23,709	460 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	7,745	55,394	395,453	1,086,050	14,440 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	2,471	18,107	63,853	126,540	4,479 90.00
91.00 09100	EMERGENCY	2,382	6,016	386,506	3,041,049	29,579 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
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
118.00	SUBTOTALS (SUM OF LINES 1-117)	64,189	367,648	4,524,760	24,151,587	514,025 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,734	39,201	0	0	1,237 192.00
192.01 19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	0	0	0 192.01
192.02 19202	LSC	0	0	0	0	0 192.02
192.03 19203	PUBLIC RELATIONS	0	0	0	0	0 192.03
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
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)	262,571	328,349	1,469,087	646,711	60,902 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141344

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

Worksheet B-1

Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (GROSS CHARGES)	PURCHASING, RECEIVING AND STORES (COSTED REQUIS.)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
203.00	Unit cost multiplier (Wkst. B, Part I)	3.755145	0.807054	0.324677	0.026777	0.118196	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	10,406	2,385	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000431	0.004629	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141344

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

Worksheet B-1

Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		COMMUNICATIONS (PHONES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (ASSIGNED SQ. FEET)	
		5.03	5A.04	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512	150					5.03
5.04	00560	18	-1,404,083	9,919,225			5.04
6.00	00600	0	0	306,936	61,531		6.00
7.00	00700	10	0	173,941	15,720	31,767	7.00
8.00	00800	0	0	48,729	0	0	8.00
9.00	00900	1	0	263,353	908	908	9.00
10.00	01000	4	0	126,044	1,106	1,106	10.00
11.00	01100	0	0	279,177	2,303	2,303	11.00
13.00	01300	8	0	280,135	271	271	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	236,840	472	472	15.00
16.00	01600	14	0	362,553	1,570	1,570	16.00
17.00	01700	2	0	125,234	56	56	17.00
19.00	01900	0	0	4,134	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	28	0	1,275,846	7,204	7,204	30.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8	0	466,122	6,286	6,286	50.00
53.00	05300	1	0	40,597	136	136	53.00
54.00	05400	6	0	1,286,378	2,614	2,614	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	5	0	1,120,313	1,150	1,150	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	59,667	280	280	62.00
65.00	06500	5	0	243,427	897	897	65.00
66.00	06600	3	0	173,771	1,181	1,181	66.00
66.01	06601	2	0	33,619	480	480	66.01
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	60,468	565	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2	0	233,756	0	0	73.00
76.00	03020	0	0	16,193	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	19	0	1,073,381	7,745	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	6	0	138,476	2,471	2,471	90.00
91.00	09100	8	0	1,426,494	2,382	2,382	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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
118.00		150	-1,404,083	9,855,584	55,797	31,767	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	63,641	5,734	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		55,095		1,404,083	350,383	288,080	202.00
203.00		367.300000		0.141552	5.694414	9.068530	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141344

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

Worksheet B-1

Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		COMMUNICATIONS	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (ASSIGNED SQ. FEET)	
		(PHONES)					
		5.03	5A.04	5.04	6.00	7.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	0		40,659	1,334	64,757	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		0.004099	0.021680	2.038499	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141344

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

Worksheet B-1
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00560						5.04
6.00	00600						6.00
7.00	00700						7.00
8.00	00800	88,754					8.00
9.00	00900	0	9,291				9.00
10.00	01000	904	308	10,022			10.00
11.00	01100	0	925	0	8,563		11.00
13.00	01300	0	28	0	252	75,633	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	21	0	0	0	15.00
16.00	01600	0	113	0	778	0	16.00
17.00	01700	0	0	0	188	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	56,171	2,227	10,022	2,130	44,310	30.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	9,996	910	0	450	9,362	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	6,961	345	0	671	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	288	0	1,069	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	0	0	62.00
65.00	06500	218	103	0	516	0	65.00
66.00	06600	1,985	231	0	168	3,490	66.00
66.01	06601	0	104	0	17	0	66.01
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	211	0	73.00
76.00	03020	0	0	0	25	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	954	0	1,006	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	9	578	0	194	0	90.00
91.00	09100	12,510	1,044	0	888	18,471	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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
118.00		88,754	8,179	10,022	8,563	75,633	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	1,112	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		55,627	314,036	171,191	383,959	336,036	202.00
203.00		0.626755	33.800022	17.081521	44.839309	4.442981	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141344

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

Worksheet B-1

Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	200	6,494	7,847	17,229	3,406	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.002253	0.698956	0.782977	2.012028	0.045033	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141344

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

Worksheet B-1
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	ADMINISTRATIVE & GENERAL						5.01
5.02	00511	PURCHASING, RECEIVING AND STORES						5.02
5.03	00512	COMMUNICATIONS						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	362,538					14.00
15.00	01500	PHARMACY	4,101	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,936	0	1,335			16.00
17.00	01700	SOCIAL SERVICE	847	0	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,874	0	512	100		30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	73,522	0	74	0	0	50.00
53.00	05300	ANESTHESIOLOGY	6,723	0	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,222	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	68,569	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	14,383	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	6,759	0	50	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,280	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	751	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,376	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	100	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	460	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	14,440	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	4,479	0	30	0	0	90.00
91.00	09100	EMERGENCY	29,579	0	666	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
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
118.00		SUBTOTALS (SUM OF LINES 1-117)	361,301	100	1,332	100	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,237	0	3	0	0	192.00
192.01	19201	RURAL HEALTH CLINIC (NON-CERTIFIED)	0	0	0	0	0	192.01
192.02	19202	LSC	0	0	0	0	0	192.02
192.03	19203	PUBLIC RELATIONS	0	0	0	0	0	192.03
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	0	278,043	475,755	152,218	4,719	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	2,780.430000	356.370787	1,522.180000	47.190000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141344

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

Worksheet B-1

Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	19.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	3,749	15,294	1,220	17	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	37.490000	11.456180	12.200000	0.170000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141344

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 7:51 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		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,471,525		2,471,525	0	0	30.00
40.00	04000 SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	750,070		750,070	0	0	50.00
53.00	05300 ANESTHESIOLOGY	53,070		53,070	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,553,168		1,553,168	0	0	54.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	1,353,541		1,353,541	0	0	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	72,246		72,246	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	335,701	0	335,701	0	0	65.00
66.00	06600 PHYSICAL THERAPY	247,895	0	247,895	0	0	66.00
66.01	06601 CARDIAC REHAB	49,741	0	49,741	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	72,244		72,244	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	554,349		554,349	0	0	73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	19,606		19,606	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	1,346,776		1,346,776	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	233,489		233,489	0	0	90.00
91.00	09100 EMERGENCY	2,065,930		2,065,930	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6,567		6,567	0	0	92.00
93.00	04040 FAMILY PRACTICE	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
99.10	09910 CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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
200.00	Subtotal (see instructions)	11,185,918	0	11,185,918	0	0	200.00
201.00	Less Observation Beds	6,567		6,567	0	0	201.00
202.00	Total (see instructions)	11,179,351	0	11,179,351	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141344

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 7:51 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,696,524		1,696,524		30.00
40.00	04000	SUBPROVIDER - I/PF	0		0		40.00
41.00	04100	SUBPROVIDER - I/RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	101,320	1,914,153	2,015,473	0.372156	50.00
53.00	05300	ANESTHESIOLOGY	42,492	258,469	300,961	0.176335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	653,292	5,702,374	6,355,666	0.244375	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	749,129	4,516,003	5,265,132	0.257076	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	206,508	50,182	256,690	0.281452	62.00
65.00	06500	RESPIRATORY THERAPY	519,412	288,947	808,359	0.415287	65.00
66.00	06600	PHYSICAL THERAPY	87,452	334,200	421,652	0.587914	66.00
66.01	06601	CARDIAC REHAB	0	48,465	48,465	1.026328	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	797,936	29,000	826,936	0.087363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,389,687	479,842	1,869,529	0.296518	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	23,709	23,709	0.826943	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	79,282	1,006,768	1,086,050		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	43,045	83,495	126,540	1.845179	90.00
91.00	09100	EMERGENCY	104,396	2,936,653	3,041,049	0.679348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,852	8,852	0.741866	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
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
200.00		Subtotal (see instructions)	6,470,475	17,681,112	24,151,587		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,470,475	17,681,112	24,151,587		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/29/2012 7:51 am
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
66.01	06601 CARDIAC REHAB	0.000000		66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
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
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 FAMILY PRACTICE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
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: 141344

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2012 7:51 am

		Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs					
			Total Costs	RCE Disallowance	Total Costs			
			1.00	2.00	3.00		4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS		2,471,525		2,471,525	0	0	30.00
40.00	04000 SUBPROVIDER - IPF		0		0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF		0		0	0	0	41.00
42.00	04200 SUBPROVIDER		0		0	0	0	42.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM		750,070		750,070	0	0	50.00
53.00	05300 ANESTHESIOLOGY		53,070		53,070	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,553,168		1,553,168	0	0	54.00
57.00	05700 CT SCAN		0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	0	59.00
60.00	06000 LABORATORY		1,353,541		1,353,541	0	0	60.00
60.01	06001 BLOOD LABORATORY		0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		72,246		72,246	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	335,701		335,701	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	247,895		247,895	0	0	66.00
66.01	06601 CARDIAC REHAB	0	49,741		49,741	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY		0		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		72,244		72,244	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		554,349		554,349	0	0	73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS		19,606		19,606	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RURAL HEALTH CLINIC		1,346,776		1,346,776	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	0	89.00
90.00	09000 CLINIC		233,489		233,489	0	0	90.00
91.00	09100 EMERGENCY		2,065,930		2,065,930	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		6,567		6,567	0	0	92.00
93.00	04040 FAMILY PRACTICE		0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES		0		0	0	0	95.00
99.10	09910 CORF		0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
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
200.00	Subtotal (see instructions)		11,185,918	0	11,185,918	0	0	200.00
201.00	Less Observation Beds		6,567		6,567	0	0	201.00
202.00	Total (see instructions)		11,179,351	0	11,179,351	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/29/2012 7:51 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	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,696,524		1,696,524	30.00
40.00	04000	SUBPROVIDER - I/PF	0		0	40.00
41.00	04100	SUBPROVIDER - I/RF	0		0	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	101,320	1,914,153	2,015,473	50.00
53.00	05300	ANESTHESIOLOGY	42,492	258,469	300,961	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	653,292	5,702,374	6,355,666	54.00
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	749,129	4,516,003	5,265,132	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	206,508	50,182	256,690	62.00
65.00	06500	RESPIRATORY THERAPY	519,412	288,947	808,359	65.00
66.00	06600	PHYSICAL THERAPY	87,452	334,200	421,652	66.00
66.01	06601	CARDIAC REHAB	0	48,465	48,465	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	797,936	29,000	826,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,389,687	479,842	1,869,529	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	23,709	23,709	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	79,282	1,006,768	1,086,050	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	43,045	83,495	126,540	90.00
91.00	09100	EMERGENCY	104,396	2,936,653	3,041,049	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,852	8,852	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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
200.00		Subtotal (see instructions)	6,470,475	17,681,112	24,151,587	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	6,470,475	17,681,112	24,151,587	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/29/2012 7:51 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
66.01	06601 CARDIAC REHAB	0.000000		66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
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
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040 FAMILY PRACTICE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
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: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part II Date/Time Prepared: 11/29/2012 7:51 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	67,696	2,015,473	0.033588	29,800	1,001	50.00
53.00	05300 ANESTHESIOLOGY	4,830	300,961	0.016049	1,833	29	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	142,454	6,355,666	0.022414	334,143	7,489	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	27,718	5,265,132	0.005264	573,022	3,016	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,051	256,690	0.007990	66,635	532	62.00
65.00	06500 RESPIRATORY THERAPY	8,980	808,359	0.011109	352,959	3,921	65.00
66.00	06600 PHYSICAL THERAPY	8,950	421,652	0.021226	28,893	613	66.00
66.01	06601 CARDIAC REHAB	14,465	48,465	0.298463	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,888	826,936	0.003492	524,467	1,831	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,056	1,869,529	0.003239	791,665	2,564	73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	128	23,709	0.005399	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	81,584	1,086,050	0.075120	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	30,765	126,540	0.243125	122	30	90.00
91.00	09100 EMERGENCY	37,009	3,041,049	0.012170	1,500	18	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	8,852	0.000000	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	435,574	22,455,063		2,705,039	21,044	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141344

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2012 7:51 am

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			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	4,719	0	0	0	0	4,719	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	4,719	0	0	0	0	4,719	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141344

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,015,473	0.000000	0.000000	29,800	50.00
53.00	05300	ANESTHESIOLOGY	0	300,961	0.015680	0.000000	1,833	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,355,666	0.000000	0.000000	334,143	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	5,265,132	0.000000	0.000000	573,022	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	256,690	0.000000	0.000000	66,635	62.00
65.00	06500	RESPIRATORY THERAPY	0	808,359	0.000000	0.000000	352,959	65.00
66.00	06600	PHYSICAL THERAPY	0	421,652	0.000000	0.000000	28,893	66.00
66.01	06601	CARDIAC REHAB	0	48,465	0.000000	0.000000	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	826,936	0.000000	0.000000	524,467	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,869,529	0.000000	0.000000	791,665	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	23,709	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,086,050	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	126,540	0.000000	0.000000	122	90.00
91.00	09100	EMERGENCY	0	3,041,049	0.000000	0.000000	1,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,852	0.000000	0.000000	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (Lines 50-199)	0	22,455,063			2,705,039	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/29/2012 7:51 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
53.00	05300 ANESTHESIOLOGY	29	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
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
66.01	06601 CARDIAC REHAB	0	0	0		66.01
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
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
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
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
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040 FAMILY PRACTICE	0	0	0		93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	29	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/29/2012 7:51 am
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Cost	
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)		Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.372156	0	697,097	0	50.00
53.00	05300 ANESTHESIOLOGY	0.176335	0	29,708	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.244375	0	1,639,563	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.257076	0	1,733,543	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281452	0	13,490	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.415287	0	167,877	0	65.00
66.00	06600 PHYSICAL THERAPY	0.587914	0	122,869	0	66.00
66.01	06601 CARDIAC REHAB	1.026328	0	31,635	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.087363	0	28,330	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.296518	0	220,456	240	73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTERS	0.826943	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000 CLINIC	1.845179	0	34,776	44	90.00
91.00	09100 EMERGENCY	0.679348	0	951,767	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741866	0	4,960	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000		0		95.00
200.00	Subtotal (see instructions)		0	5,676,071	284	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	5,676,071	284	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/29/2012 7:51 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs					
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	259,429	0	50.00
53.00	05300	ANESTHESIOLOGY	0	5,239	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	400,668	0	54.00
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	445,652	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	3,797	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	69,717	0	65.00
66.00	06600	PHYSICAL THERAPY	0	72,236	0	66.00
66.01	06601	CARDIAC REHAB	0	32,468	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,475	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	65,369	71	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
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
90.00	09000	CLINIC	0	64,168	81	90.00
91.00	09100	EMERGENCY	0	646,581	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,680	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	0	2,071,479	152	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	2,071,479	152	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141344 Component CCN: 14Z344	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/29/2012 7:51 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.372156	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.176335	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.244375	0	0	0	54.00
57.00 05700 CT SCAN	0.000000	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 06000 LABORATORY	0.257076	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	0.281452	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0.415287	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.587914	0	0	0	66.00
66.01 06601 CARDIAC REHAB	1.026328	0	0	0	66.01
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.087363	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.296518	0	0	0	73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0.826943	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00 09000 CLINIC	1.845179	0	0	0	90.00
91.00 09100 EMERGENCY	0.679348	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741866	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.000000		0		95.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141344 Component CCN: 14Z344	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/29/2012 7:51 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs					
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
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
66.01	06601	CARDIAC REHAB	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
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
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
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
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/29/2012 7:51 am
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges		
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.372156	0	536,905	0	50.00
53.00 05300 ANESTHESIOLOGY	0.176335	0	14,468	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.244375	0	1,654,540	0	54.00
57.00 05700 CT SCAN	0.000000	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 06000 LABORATORY	0.257076	0	968,419	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281452	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0.415287	0	84,475	0	65.00
66.00 06600 PHYSICAL THERAPY	0.587914	0	46,784	0	66.00
66.01 06601 CARDIAC REHAB	1.026328	0	1,283	0	66.01
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.087363	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.296518	0	111,631	0	73.00
76.00 03020 OTHER ANCILLARY SERVICE COST CENTERS	0.826943	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	1.240068				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00 09000 CLINIC	1.845179	0	28,790	0	90.00
91.00 09100 EMERGENCY	0.679348	0	1,031,478	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.741866	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0.000000	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.000000	0	0		95.00
200.00 Subtotal (see instructions)		0	4,478,773	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	4,478,773	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/29/2012 7:51 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs					
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	199,812	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,551	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	404,328	0	54.00
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	248,957	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	35,081	0	65.00
66.00	06600	PHYSICAL THERAPY	0	27,505	0	66.00
66.01	06601	CARDIAC REHAB	0	1,317	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
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	33,101	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
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
90.00	09000	CLINIC	0	53,123	0	90.00
91.00	09100	EMERGENCY	0	700,733	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	0	1,706,508	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	1,706,508	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/29/2012 7:51 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,039	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,212	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)		2,204	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		791	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		18	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)		18	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,716	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)		791	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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		173.64	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		178.85	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,471,525	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)		3,126	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)		3,219	25.00
26.00	Total swing-bed cost (see instructions)		655,685	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,815,840	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,526,021	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,526,021	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.189918	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)		692.39	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)		1,815,840	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		820.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,408,682	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)		1,408,682	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/29/2012 7:51 am
Cost Center Description			Title XVIII		Hospital
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				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)				704,506 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,113,188 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)				649,340 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				649,340 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)				8 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				820.90 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				6,567 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141344

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

Worksheet D-1
Date/Time Prepared:
11/29/2012 7:51 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: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/29/2012 7:51 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,039	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,212	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)		2,204	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		791	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		18	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)		18	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		214	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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		202.30	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		208.37	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,471,525	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)		3,641	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)		3,751	25.00
26.00	Total swing-bed cost (see instructions)		656,455	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,815,070	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	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)		0.00	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)		1,815,070	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		820.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		175,600	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)		175,600	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/29/2012 7:51 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00
42.00	Intensive Care Type Inpatient Hospital Units					42.00
43.00	INTENSIVE CARE UNIT					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)					140,366
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					315,966
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					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)					8
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					820.56
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,564

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141344

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

Worksheet D-1
Date/Time Prepared:
11/29/2012 7:51 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: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/29/2012 7:51 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,133,984	30.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
41.00	04100	SUBPROVIDER - I/RP		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.372156	29,800	50.00
53.00	05300	ANESTHESIOLOGY	0.176335	1,833	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244375	334,143	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.257076	573,022	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281452	66,635	62.00
65.00	06500	RESPIRATORY THERAPY	0.415287	352,959	65.00
66.00	06600	PHYSICAL THERAPY	0.587914	28,893	66.00
66.01	06601	CARDIAC REHAB	1.026328	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.087363	524,467	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.296518	791,665	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.826943	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.845179	122	90.00
91.00	09100	EMERGENCY	0.679348	1,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.741866	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,705,039	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)		2,705,039	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141344	Period: From 07/01/2011	Worksheet D-3	
		Component CCN: 14Z344	To 06/30/2012	Date/Time Prepared: 11/29/2012 7:51 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.372156	0	50.00
53.00	05300	ANESTHESIOLOGY	0.176335	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244375	41,220	10,073
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.257076	88,840	22,839
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281452	13,823	3,891
65.00	06500	RESPIRATORY THERAPY	0.415287	137,861	57,252
66.00	06600	PHYSICAL THERAPY	0.587914	50,868	29,906
66.01	06601	CARDIAC REHAB	1.026328	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.087363	211,288	18,459
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.296518	357,236	105,927
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.826943	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0
90.00	09000	CLINIC	1.845179	0	90.00
91.00	09100	EMERGENCY	0.679348	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.741866	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		901,136	248,347
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	
202.00		Net Charges (line 200 minus line 201)		901,136	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/29/2012 7:51 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		148,200	30.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
41.00	04100	SUBPROVIDER - I/RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.372156	30,345	50.00
53.00	05300	ANESTHESIOLOGY	0.176335	13,464	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244375	59,939	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.257076	87,267	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.281452	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.415287	28,062	65.00
66.00	06600	PHYSICAL THERAPY	0.587914	1,904	66.00
66.01	06601	CARDIAC REHAB	1.026328	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.087363	50,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.296518	110,129	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTERS	0.826943	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.240068	7,238	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.845179	13,809	90.00
91.00	09100	EMERGENCY	0.679348	7,844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.741866	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		410,411	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)		410,411	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/29/2012 7:51 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,071,631 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)			2,071,631 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			2,092,347 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			36,422 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			772,605 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,283,320 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,283,320 30.00
31.00	Primary payer payments			288 31.00
32.00	Subtotal (line 30 minus line 31)			1,283,032 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			157,627 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			157,627 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			139,725 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,440,659 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)			1,440,659 40.00
41.00	Interim payments			1,440,417 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)			242 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141344

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

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2012 7:51 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,719,797		1,440,417	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,719,797		1,440,417	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		129,409		242	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,849,206		1,440,659	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: 141344
Component CCN: 14Z344

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

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2012 7:51 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		827,322		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	03/27/2012	15,800		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		15,800		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)		843,122		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		37,584		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		880,706		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet E-2
Component CCN: 14Z344		Date/Time Prepared: 11/29/2012 7:51 am
Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	655,833	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)	250,830	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	791	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)	906,663	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	906,663	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)	906,663	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	25,957	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)	880,706	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)	880,706	0	19.00
20.00	Interim payments	843,122	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)	37,584	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 11/29/2012 7:51 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		2,113,188	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)		2,113,188	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,134,320	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,134,320	19.00
20.00	Deductibles (exclude professional component)		353,943	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		1,780,377	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,780,377	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		68,829	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		68,829	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		56,516	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,849,206	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		1,849,206	30.00
31.00	Interim payments		1,719,797	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)		129,409	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2012 7:51 am
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		315,966	1.00
2.00	Medical and other services		1,706,508	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,022,474	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)		2,022,474	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		4,889,184	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)		4,889,184	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		4,889,184	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,866,710	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,022,474	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		2,022,474	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,022,474	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2,022,474	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		2,022,474	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)		2,022,474	40.00
41.00	Interim payments		2,022,474	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 141344

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

Worksheet G

Date/Time Prepared:
11/29/2012 7:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	608,312	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,239,095	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,750,814	0	0	0	6.00
7.00	Inventory	249,003	0	0	0	7.00
8.00	Prepaid expenses	108,632	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	7,214	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,461,442	0	0	0	11.00
FIXED ASSETS						
12.00	Land	20,150	0	0	0	12.00
13.00	Land improvements	353,171	0	0	0	13.00
14.00	Accumulated depreciation	-198,651	0	0	0	14.00
15.00	Buildings	5,386,782	0	0	0	15.00
16.00	Accumulated depreciation	-2,981,163	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	497,869	0	0	0	19.00
20.00	Accumulated depreciation	-354,275	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	4,952,990	0	0	0	23.00
24.00	Accumulated depreciation	-4,111,667	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)	3,565,206	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,026,650	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,060,514	0	0	0	37.00
38.00	Salaries, wages, and fees payable	508,970	0	0	0	38.00
39.00	Payroll taxes payable	53,047	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	732,821	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,355,352	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	209,844	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	209,844	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,565,196	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	4,461,454				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)	4,461,454	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,026,650	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141344

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

Worksheet G-1

Date/Time Prepared:
11/29/2012 7:51 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		4,462,505	
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,051			2.00
3.00	Total (sum of line 1 and line 2)		4,461,454		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		4,461,454		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)		4,461,454		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141344

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

Worksheet G-1

Date/Time Prepared:
11/29/2012 7:51 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141344

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2012 7:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,526,021		1,526,021	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	251,465		251,465	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,777,486		1,777,486	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,777,486		1,777,486	17.00
18.00	Ancillary services	4,638,383	17,896,379	22,534,762	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	143,499	143,499	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	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				26.00
27.00	OTHER (SPECIFY)	123,654	1,686,234	1,809,888	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,539,523	19,726,112	26,265,635	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,310,022		29.00
30.00	BAD DEBT EXPENSE	1,175,597			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,175,597		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,485,619		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141344

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

Worksheet G-3

Date/Time Prepared:
11/29/2012 7:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	26,265,635	1.00
2.00	Less contractual allowances and discounts on patients' accounts	13,368,162	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,897,473	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,485,619	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-588,146	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	35,130	6.00
7.00	Income from investments	7,133	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	65,989	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	6,393	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	50,956	23.00
24.00	GRANTS, PURCHASING DISCOUNTS, RENT	421,494	24.00
25.00	Total other income (sum of lines 6-24)	587,095	25.00
26.00	Total (line 5 plus line 25)	-1,051	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,051	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1 Date/Time Prepared: 11/29/2012 7:51 am
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		Title XVIII		Rural Health Clinic (RHC) I	Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	78,780	0	78,780	0	78,780	2.00
3.00	Nurse Practitioner	83,575	0	83,575	0	83,575	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	233,098	0	233,098	0	233,098	9.00
10.00	Subtotal (sum of lines 1-9)	395,453	0	395,453	0	395,453	10.00
11.00	Physician Services Under Agreement	0	330,300	330,300	0	330,300	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	330,300	330,300	0	330,300	14.00
15.00	Medical Supplies	0	5,043	5,043	0	5,043	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	25,277	25,277	0	25,277	18.00
19.00	Other Health Care Costs	0	9,397	9,397	0	9,397	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	39,717	39,717	0	39,717	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	395,453	370,017	765,470	0	765,470	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	5,204	5,204	0	5,204	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	130	130	0	130	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	5,334	5,334	0	5,334	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	3,735	3,735	10,369	14,104	29.00
30.00	Administrative Costs	0	76,683	76,683	0	76,683	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	80,418	80,418	10,369	90,787	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	395,453	455,769	851,222	10,369	861,591	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141344 Component CCN: 143499	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1 Date/Time Prepared: 11/29/2012 7:51 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	78,780
3.00	Nurse Practitioner	0	83,575
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	233,098
10.00	Subtotal (sum of lines 1-9)	0	395,453
11.00	Physician Services Under Agreement	-28,161	302,139
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	-28,161	302,139
15.00	Medical Supplies	0	5,043
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	25,277
19.00	Other Health Care Costs	0	9,397
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	39,717
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-28,161	737,309
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	5,204
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	130
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	5,334
FACILITY OVERHEAD			
29.00	Facility Costs	0	14,104
30.00	Administrative Costs	0	76,683
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	90,787
32.00	Total facility costs (sum of lines 22, 28 and 31)	-28,161	833,430

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet M-2		
		Component CCN: 143499		Date/Time Prepared: 11/29/2012 7:51 am		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.50	4,527	4,200	6,300	1.00
2.00	Physician Assistant	0.88	2,546	2,100	1,848	2.00
3.00	Nurse Practitioner	0.86	2,636	2,100	1,806	3.00
4.00	Subtotal (sum of lines 1-3)	3.24	9,709		9,954	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)	3.24	9,709		9,954	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)				737,309	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				5,334	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				742,643	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				0.992818	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				90,787	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				513,346	15.00
16.00	Total overhead (sum of lines 14 and 15)				604,133	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				604,133	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				599,794	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,337,103	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3
		Component CCN: 143499		Date/Time Prepared: 11/29/2012 7:51 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,337,103	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		4,549	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,332,554	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		9,954	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)		9,954	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		133.87	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	133.87	133.87	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,446	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	327,446	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	327,446	16.00
16.01	Total program charges (see instructions)(from contractor's records)		227,573	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,567	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,449	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.)		230,478	16.04
16.05	Total program cost (see instructions)		239,927	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		29,899	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		239,927	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,609	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		242,536	22.00
23.00	Reimbursable bad debts (see instructions)		32	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)		242,568	26.00
27.00	Interim payments		247,345	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		-4,777	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141344	Period:	Worksheet M-4
		Component CCN: 143499	From 07/01/2011 To 06/30/2012	Date/Time Prepared: 11/29/2012 7:51 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	395,453	395,453	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.003215	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	1,271	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	1,229	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	2,500	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	737,309	737,309	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	604,133	604,133	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.003391	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	2,049	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	4,549	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	136	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	33.45	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	78	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	2,609	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		4,549	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		2,609	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141344	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5
	Component CCN: 143499		Date/Time Prepared: 11/29/2012 7:51 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		247,345	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		247,345	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		4,777	6.02
7.00	Total Medicare program liability (see instructions)		242,568	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00