This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure 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: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 1/25/2012 5:56 pm

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 1/25/2012 Time: 5:56 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [0] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 GRAHAM HOSPITAL ASSOCIATION for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	499,931	-262,030	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	Skilled Nursing Facility	0	153,289	6		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 (RHC) I	0		85,555		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	653,220	-176,469	0	0	200.00

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

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FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 1/25/2012 5:56 pm

PART I - COST REPORT STATUS

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4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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   (3) Settled with Audit
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6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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Encryption Information

ECR: Date: 1/25/2012 Time: 5:56 pm
ySTTrq5llGWgE01exttvF34b181Iz0
UTBm80:3wfT92MnrpF4ZN7IRvTNNWK
0QU01FXe.G0qXEQR

PI: Date: 1/25/2012 Time: 5:56 pm
8NuqalIEbNxG6kU9I0qRcWUnED2331
1KjT00h.bq.ebnOHqjiw7xG2UdqM2f
GS.cakrklM0d00JA

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	499,931	-262,030	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	Skilled Nursing Facility	0	153,289	6		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 (RHC) I	0		85,555		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	653,220	-176,469	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: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 210 WEST WALNUT	PO Box:			1.00
2.00	City: CANTON	State: IL	Zip Code: 61520-	County: FULTON	2.00

		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	GRAHAM HOSPITAL ASSOCIATION	140001	99914	1	07/19/1966	N	P	N	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						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N	9.00
10.00	Hospital-Based NF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GRAHAM HOSPITAL HOME HEALTH AGENCY	147142	99914		06/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GRAHAM HOSPITAL HOSPICE	141558	99914		07/28/1993				14.00
15.00	Hospital-Based Health Clinic - RHC	COLEMAN CLINIC	143493	99914		01/01/2008	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2010	06/30/2011	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	1,735	0	0	0	151	0	24.00
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0	25.00

		1.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.	2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1	35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/25/2012 5:44 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	07/01/2010	06/30/2011	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	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00

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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N	80.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/25/2012 5:44 pm

		1.00	
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N	86.00

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	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.	Y	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	1,000,000	3,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	Y	Y	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/25/2012 5:44 pm

		1.00	2.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	
		1.00	2.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)			
155.00	Hospital	N	N	155.00
156.00	Subprovider - IPF	N	N	156.00
157.00	Subprovider - IRF	N	N	157.00
158.00	Subprovider - Other	N	N	158.00
159.00	SNF	N	N	159.00
160.00	HHA	N	N	160.00
161.00	CMHC		N	161.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/25/2012 5:44 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		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.	Y			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y	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.	Y		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.	Y	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	10/07/2011	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: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/25/2012 5:44 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					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.					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.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II Date/Time Prepared: 1/25/2012 5:44 pm

		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	10/07/2011	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		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	44	15,220	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		44	15,220	0.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00					13.00
14.00	Total (see instructions)		49	17,045	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	32	11,680			19.00
20.00	NURSING FACILITY	45.00	18	6,570			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	88.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		99				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	3,993	1,250	7,422		1.00
2.00	HMO		989	151			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,993	1,250	7,422		7.00
8.00	INTENSIVE CARE UNIT	0	410	66	745		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0		419	589		13.00
14.00	Total (see instructions)	0	4,403	1,735	8,756		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	4,694	338	7,575		19.00
20.00	NURSING FACILITY	0		4,473	6,414		20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	3,019	503	5,720		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE		0	0	0		24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	0	16,909	0	90,544		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	0		0	1,404		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				105		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: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	1,072	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	475.15	0.00	0	1,072	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	29.68	0.00			19.00
20.00	NURSING FACILITY	0.00	16.94	0.00			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	8.71	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00	5.26	0.00			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	0.00	66.73	0.00			26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	602.47	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	466	2,350		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)	466	2,350		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC (RHC)				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part II Date/Time Prepared: 1/25/2012 5:44 pm

		Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	
		1.00	2.00	2.50	3.00	4.00	
	PART II - WAGE DATA						
	SALARIES						
1.00	Total salaries (see instructions)	200.00	28,007,964	0	0	28,007,964	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0	2.00
3.00	Non-physician anesthetist Part B		1,084,964	0	0	1,084,964	3.00
4.00	Physician-Part A		31,005	0	0	31,005	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0	4.01
5.00	Physician-Part B		2,299,912	0	0	2,299,912	5.00
6.00	Non-physician-Part B		2,045,740	0	0	2,045,740	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0	7.01
8.00	Home office personnel		0	0	0	0	8.00
9.00	SNF	44.00	1,131,048	0	0	1,131,048	9.00
10.00	Excluded area salaries (see instructions)		2,217,817	0	67,162	2,284,979	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		32,684	0	0	32,684	11.00
12.00	Management and administrative services		0	0	0	0	12.00
13.00	Contract labor: physician-Part A		0	0	0	0	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0	14.00
15.00	Home office: physician Part A		0	0	0	0	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		4,683,089	0	0	4,683,089	17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		216,870	0	0	216,870	18.00
19.00	Excluded areas		833,066	0	0	833,066	19.00
20.00	Non-physician anesthetist Part A		0	0	0	0	20.00
21.00	Non-physician anesthetist Part B		128,778	0	0	128,778	21.00
22.00	Physician Part A		28,604	0	0	28,604	22.00
23.00	Physician Part B		250,850	0	0	250,850	23.00
24.00	Wage-related costs (RHC/FQHC)		587,164	0	0	587,164	24.00
25.00	Interns & residents (in an approved program)		0	0	0	0	25.00
	OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	207,549	0	0	207,549	26.00
27.00	Administrative & General	5.00	4,861,795	0	0	4,861,795	27.00
28.00	Administrative & General under contract (see inst.)		80,023	0	0	80,023	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0	29.00
30.00	Operation of Plant	7.00	826,996	0	-4,019	822,977	30.00
31.00	Laundry & Linen Service	8.00	22,670	0	0	22,670	31.00
32.00	Housekeeping	9.00	589,717	0	0	589,717	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0	33.00
34.00	Dietary	10.00	629,800	0	-346,799	283,001	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0	35.00
36.00	Cafeteria	11.00	0	0	346,799	346,799	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0	37.00
38.00	Nursing Administration	13.00	478,667	0	0	478,667	38.00
39.00	Central Services and Supply	14.00	35,644	0	0	35,644	39.00
40.00	Pharmacy	15.00	599,496	0	0	599,496	40.00
41.00	Medical Records & Medical Records Library	16.00	481,197	0	0	481,197	41.00
42.00	Social Service	17.00	0	0	0	0	42.00
43.00	Other General Service	18.00	0	0	0	0	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part II | Date/Time Prepared: 1/25/2012 5:44 pm

		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
		5.00	6.00		
	PART II - WAGE DATA				
	SALARIES				
1.00	Total salaries (see instructions)	1,253,139.00	22.35		1.00
2.00	Non-physician anesthetist Part A	0.00	0.00		2.00
3.00	Non-physician anesthetist Part B	10,403.00	104.29		3.00
4.00	Physician-Part A	145.00	213.83		4.00
4.01	Physicians - Part A - direct teaching	0.00	0.00		4.01
5.00	Physician-Part B	22,108.00	104.03		5.00
6.00	Non-physician-Part B	128,719.00	15.89		6.00
7.00	Interns & residents (in an approved program)	0.00	0.00		7.00
7.01	Contracted interns and residents (in approved programs)	0.00	0.00		7.01
8.00	Home office personnel	0.00	0.00		8.00
9.00	SNF	61,726.00	18.32		9.00
10.00	Excluded area salaries (see instructions)	105,549.00	21.65		10.00
	OTHER WAGES & RELATED COSTS				
11.00	Contract labor (see instructions)	519.00	62.97		11.00
12.00	Management and administrative services	0.00	0.00		12.00
13.00	Contract labor: physician-Part A	0.00	0.00		13.00
14.00	Home office salaries & wage-related costs	0.00	0.00		14.00
15.00	Home office: physician Part A	0.00	0.00		15.00
16.00	Teaching physician salaries (see instructions)	0.00	0.00		16.00
	WAGE-RELATED COSTS				
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24				17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25				18.00
19.00	Excluded areas				19.00
20.00	Non-physician anesthetist Part A				20.00
21.00	Non-physician anesthetist Part B				21.00
22.00	Physician Part A				22.00
23.00	Physician Part B				23.00
24.00	Wage-related costs (RHC/FQHC)				24.00
25.00	Interns & residents (in an approved program)				25.00
	OVERHEAD COSTS - DIRECT SALARIES				
26.00	Employee Benefits	10,827.00	19.17		26.00
27.00	Administrative & General	226,596.00	21.46		27.00
28.00	Administrative & General under contract (see inst.)	416.00	192.36		28.00
29.00	Maintenance & Repairs	0.00	0.00		29.00
30.00	Operation of Plant	50,102.00	16.43		30.00
31.00	Laundry & Linen Service	2,187.00	10.37		31.00
32.00	Housekeeping	54,583.00	10.80		32.00
33.00	Housekeeping under contract (see instructions)	0.00	0.00		33.00
34.00	Dietary	23,960.00	11.81		34.00
35.00	Dietary under contract (see instructions)	0.00	0.00		35.00
36.00	Cafeteria	29,361.00	11.81		36.00
37.00	Maintenance of Personnel	0.00	0.00		37.00
38.00	Nursing Administration	15,946.00	30.02		38.00
39.00	Central Services and Supply	2,994.00	11.91		39.00
40.00	Pharmacy	24,644.00	24.33		40.00
41.00	Medical Records & Medical Records Library	36,787.00	13.08		41.00
42.00	Social Service	0.00	0.00		42.00
43.00	Other General Service	0.00	0.00		43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part III Date/Time Prepared: 1/25/2012 5:44 pm

		Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	
		1.00	2.00	2.50	3.00	4.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)		22,626,366	0	0	22,626,366	1.00
2.00	Excluded area salaries (see instructions)		3,348,865	0	67,162	3,416,027	2.00
3.00	Subtotal salaries (line 1 minus line 2)		19,277,501	0	-67,162	19,210,339	3.00
4.00	Subtotal other wages & related costs (see inst.)		32,684	0	0	32,684	4.00
5.00	Subtotal wage-related costs (see inst.)		4,928,563	0	0	4,928,563	5.00
6.00	Total (sum of lines 3 thru 5)		24,238,748	0	-67,162	24,171,586	6.00
7.00	Total overhead cost (see instructions)		8,813,554	0	-4,019	8,809,535	7.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part III | Date/Time Prepared: 1/25/2012 5:44 pm

		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
		5.00	6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY				
1.00	Net salaries (see instructions)	1,092,325.00	20.71		1.00
2.00	Excluded area salaries (see instructions)	167,275.00	20.42		2.00
3.00	Subtotal salaries (line 1 minus line 2)	925,050.00	20.77		3.00
4.00	Subtotal other wages & related costs (see inst.)	519.00	62.97		4.00
5.00	Subtotal wage-related costs (see inst.)	0.00	25.66		5.00
6.00	Total (sum of lines 3 thru 5)	925,569.00	26.12		6.00
7.00	Total overhead cost (see instructions)	478,403.00	18.41		7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part IV Date/Time Prepared: 1/25/2012 5:44 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	551,993	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	11,433	6.00
7.00	Employee Managed Care Program Administration Fees	247,011	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,950,265	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	17,839	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	154,799	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	461,719	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,917,841	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	49,719	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	11,164	22.00
23.00	Tuition Reimbursement	137,770	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,511,553	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	216,870	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part V Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	32,684	0	1.00
2.00	Hospital	32,684	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00		0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140001 | Component CCN: 147142 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-4 | Date/Time Prepared: 1/25/2012 5:44 pm

Home Health Agency I | PPS

		1.00	
0.00	County	MCLEAN	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,379	179	812	2,370	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	146.00	19.00	86.00	251.00	2.00

			Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week	Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.50	0.00	0.50	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		1.84	0.00	1.84	5.00
6.00	Direct Nursing Service		4.03	0.00	4.03	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.64	0.00	0.64	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.12	0.00	0.12	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.01	0.01	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.44	0.00	0.44	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		1.14	0.00	1.14	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,450	542	133	27	2,152	21.00
22.00	Skilled Nursing Visit Charges	243,693	90,829	22,375	4,556	361,453	22.00
23.00	Physical Therapy Visits	343	1	31	6	381	23.00
24.00	Physical Therapy Visit Charges	62,710	184	5,679	1,101	69,674	24.00
25.00	Occupational Therapy Visits	78	0	0	7	85	25.00
26.00	Occupational Therapy Visit Charges	14,198	0	0	1,285	15,483	26.00
27.00	Speech Pathology Visits	6	0	0	0	6	27.00
28.00	Speech Pathology Visit Charges	1,049	0	0	0	1,049	28.00
29.00	Medical Social Service Visits	23	3	1	1	28	29.00
30.00	Medical Social Service Visit Charges	5,340	685	233	233	6,491	30.00
31.00	Home Health Aide Visits	339	16	0	12	367	31.00
32.00	Home Health Aide Visit Charges	35,615	1,692	0	1,269	38,576	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,239	562	165	53	3,019	33.00
34.00	Other Charges	4,850	4,570	875	505	10,800	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	367,455	97,960	29,162	8,949	503,526	35.00
36.00	Total Number of Episodes (standard/non outlier)	158		61	3	222	36.00
37.00	Total Number of Outlier Episodes		12		0	12	37.00
38.00	Total Non-Routine Medical Supply Charges	11,871	5,277	5,925	333	23,406	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet S-7 Date/Time Prepared: 1/25/2012 5:44 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	9	0	9	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	24	0	24	7.00
8.00		RHL	37	0	37	8.00
9.00		RMX	270	0	270	9.00
10.00		RML	530	0	530	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	16	0	16	16.00
17.00		RVA	34	0	34	17.00
18.00		RHC	31	0	31	18.00
19.00		RHB	168	0	168	19.00
20.00		RHA	824	0	824	20.00
21.00		RMC	137	0	137	21.00
22.00		RMB	429	0	429	22.00
23.00		RMA	1,533	0	1,533	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	37	0	37	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	19	0	19	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	10	0	10	34.00
35.00		HB2	14	0	14	35.00
36.00		HB1	35	0	35	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	2	0	2	39.00
40.00		LD1	33	0	33	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	6	0	6	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	2	0	2	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	29	0	29	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	18	0	18	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	24	0	24	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	152	0	152	54.00
55.00		SE3	53	0	53	55.00
56.00		SE2	110	0	110	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	45	0	45	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	23	0	23	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	8	0	8	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-7 | Date/Time Prepared: 1/25/2012 5:44 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	14	0	14	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	14	0	14	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	4	0	4	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,694	0	4,694	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99916	99916	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,131,048	100.00	N	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	1,404	0.00	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,573,037			207.00

			1.00	
1.00	Wage Index Factor		0.0000	1.00

		Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate On/After 10/1	
		1.00	2.00	3.00	4.00	5.00	
3.00		RUX	195.01	195.01	0	269.98	3.00
4.00		RUL	174.43	174.43	0	263.50	4.00
5.00		RVX	146.09	146.09	0	241.45	5.00
6.00		RVL	137.14	137.14	0	215.54	6.00
7.00		RHX	122.05	122.05	0	219.66	7.00
8.00		RHL	119.37	119.37	0	194.67	8.00
9.00		RMX	136.16	136.16	0	201.49	9.00
10.00		RML	125.88	125.88	0	184.83	10.00
11.00		RLX	96.39	96.39	0	117.63	11.00
12.00		RUC	169.51	169.51	0	201.03	12.00
13.00		RUB	156.99	156.99	0	201.03	13.00
14.00		RUA	150.72	150.72	0	165.39	14.00
15.00		RVC	132.66	132.66	0	172.50	15.00
16.00		RVB	126.85	126.85	0	147.98	16.00
17.00		RVA	116.12	116.12	0	147.51	17.00
18.00		RHC	113.11	113.11	0	150.71	18.00
19.00		RHB	108.63	108.63	0	134.98	19.00
20.00		RHA	101.92	101.92	0	117.85	20.00
21.00		RMC	103.51	103.51	0	133.00	21.00
22.00		RMB	100.82	100.82	0	123.74	22.00
23.00		RMA	99.04	99.04	0	100.60	23.00
24.00		RLB	89.24	89.24	0	129.97	24.00
25.00		RLA	77.16	77.16	0	80.92	25.00
26.00		ES3	195.98	195.98	0	195.98	26.00
27.00		ES2	153.87	153.87	0	153.87	27.00
28.00		ES1	137.67	137.67	0	137.67	28.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-7 | Date/Time Prepared: 1/25/2012 5:44 pm

		Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate On/After 10/1	
		1.00	2.00	3.00	4.00	5.00	
29.00		HE2	133.04	133.04	0	133.04	29.00
30.00		HE1	110.83	110.83	0	110.83	30.00
31.00		HD2	124.71	124.71	0	124.71	31.00
32.00		HD1	104.35	104.35	0	104.35	32.00
33.00		HC2	117.77	117.77	0	117.77	33.00
34.00		HC1	98.80	98.80	0	98.80	34.00
35.00		HB2	116.38	116.38	0	116.38	35.00
36.00		HB1	97.87	97.87	0	97.87	36.00
37.00		LE2	121.01	121.01	0	121.01	37.00
38.00		LE1	101.57	101.57	0	101.57	38.00
39.00		LD2	116.38	116.38	0	116.38	39.00
40.00		LD1	97.87	97.87	0	97.87	40.00
41.00		LC2	102.50	102.50	0	102.50	41.00
42.00		LC1	86.76	86.76	0	86.76	42.00
43.00		LB2	97.41	97.41	0	97.41	43.00
44.00		LB1	83.06	83.06	0	83.06	44.00
45.00		CE2	108.05	108.05	0	108.05	45.00
46.00		CE1	99.72	99.72	0	99.72	46.00
47.00		CD2	102.50	102.50	0	102.50	47.00
48.00		CD1	94.17	94.17	0	94.17	48.00
49.00		CC2	79.84	79.84	0	90.00	49.00
50.00		CC1	73.58	73.58	0	83.53	50.00
51.00		CB2	70.00	70.00	0	83.53	51.00
52.00		CB1	66.87	66.87	0	77.51	52.00
53.00		CA2	66.42	66.42	0	71.03	53.00
54.00		CA1	62.84	62.84	0	66.40	54.00
55.00		SE3	106.23	106.23	0	0.00	55.00
56.00		SE2	91.03	91.03	0	0.00	56.00
57.00		SE1	81.63	81.63	0	0.00	57.00
58.00		SSC	80.29	80.29	0	0.00	58.00
59.00		SSB	76.27	76.27	0	0.00	59.00
60.00		SSA	74.92	74.92	0	0.00	60.00
61.00		IB2	60.16	60.16	0	0.00	61.00
62.00		IB1	59.27	59.27	0	0.00	62.00
63.00		IA2	54.79	54.79	0	0.00	63.00
64.00		IA1	53.00	53.00	0	0.00	64.00
65.00		BB2	59.71	59.71	0	75.20	65.00
66.00		BB1	58.37	58.37	0	71.96	66.00
67.00		BA2	54.35	54.35	0	62.70	67.00
68.00		BA1	50.77	50.77	0	59.93	68.00
69.00		PE2	64.63	64.63	0	99.72	69.00
70.00		PE1	63.74	63.74	0	95.10	70.00
71.00		PD2	61.50	61.50	0	94.17	71.00
72.00		PD1	60.61	60.61	0	89.54	72.00
73.00		PC2	58.82	58.82	0	81.21	73.00
74.00		PC1	58.37	58.37	0	77.51	74.00
75.00		PB2	52.56	52.56	0	69.18	75.00
76.00		PB1	51.66	51.66	0	66.40	76.00
77.00		PA2	51.21	51.21	0	57.61	77.00
78.00		PA1	49.87	49.87	0	55.30	78.00
199.00		AAA	49.87	49.87	0	0.00	199.00
200.00	TOTAL				0		200.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-7 | Date/Time Prepared: 1/25/2012 5:44 pm

		Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total		
		6.00	7.00	8.00		
3.00		269.98	0	0		3.00
4.00		263.50	0	0		4.00
5.00		241.45	0	0		5.00
6.00		215.54	0	0		6.00
7.00		219.66	0	0		7.00
8.00		194.67	0	0		8.00
9.00		201.49	0	0		9.00
10.00		184.83	0	0		10.00
11.00		117.63	0	0		11.00
12.00		201.03	0	0		12.00
13.00		201.03	0	0		13.00
14.00		165.39	0	0		14.00
15.00		172.50	0	0		15.00
16.00		147.98	0	0		16.00
17.00		147.51	0	0		17.00
18.00		150.71	0	0		18.00
19.00		134.98	0	0		19.00
20.00		117.85	0	0		20.00
21.00		133.00	0	0		21.00
22.00		123.74	0	0		22.00
23.00		100.60	0	0		23.00
24.00		129.97	0	0		24.00
25.00		80.92	0	0		25.00
26.00		195.98	0	0		26.00
27.00		153.87	0	0		27.00
28.00		137.67	0	0		28.00
29.00		133.04	0	0		29.00
30.00		110.83	0	0		30.00
31.00		124.71	0	0		31.00
32.00		104.35	0	0		32.00
33.00		117.77	0	0		33.00
34.00		98.80	0	0		34.00
35.00		116.38	0	0		35.00
36.00		97.87	0	0		36.00
37.00		121.01	0	0		37.00
38.00		101.57	0	0		38.00
39.00		116.38	0	0		39.00
40.00		97.87	0	0		40.00
41.00		102.50	0	0		41.00
42.00		86.76	0	0		42.00
43.00		97.41	0	0		43.00
44.00		83.06	0	0		44.00
45.00		108.05	0	0		45.00
46.00		99.72	0	0		46.00
47.00		102.50	0	0		47.00
48.00		94.17	0	0		48.00
49.00		90.00	0	0		49.00
50.00		83.53	0	0		50.00
51.00		83.53	0	0		51.00
52.00		77.51	0	0		52.00
53.00		71.03	0	0		53.00
54.00		66.40	0	0		54.00
55.00		0.00	0	0		55.00
56.00		0.00	0	0		56.00
57.00		0.00	0	0		57.00
58.00		0.00	0	0		58.00
59.00		0.00	0	0		59.00
60.00		0.00	0	0		60.00
61.00		0.00	0	0		61.00
62.00		0.00	0	0		62.00
63.00		0.00	0	0		63.00
64.00		0.00	0	0		64.00
65.00		75.20	0	0		65.00
66.00		71.96	0	0		66.00
67.00		62.70	0	0		67.00
68.00		59.93	0	0		68.00
69.00		99.72	0	0		69.00
70.00		95.10	0	0		70.00
71.00		94.17	0	0		71.00
72.00		89.54	0	0		72.00
73.00		81.21	0	0		73.00
74.00		77.51	0	0		74.00
75.00		69.18	0	0		75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-7 | Date/Time Prepared: 1/25/2012 5:44 pm

		Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	Total		
		6.00	7.00	8.00		
76.00		66.40	0	0		76.00
77.00		57.61	0	0		77.00
78.00		55.30	0	0		78.00
199.00		0.00	0	0		199.00
200.00	TOTAL		0	0		200.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 140001 Component CCN: 143493

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

Worksheet S-8

Date/Time Prepared: 1/25/2012 5:44 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	180 S MAIN STREET	1.00
		City / State / Zip Code	
		1.00 / 2.00 / 3.00	
2.00	City, State, Zip Code, County	CANTON IL 61520	2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award / Date	
		1.00 / 2.00	
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
9.01		0	9.01
9.02		0	9.02
9.03		0	9.03
9.04		0	9.04
9.05		0	9.05
9.06		0	9.06
9.07		0	9.07
9.08		0	9.08
9.09		0	9.09
9.10		0	9.10
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	Clinic	08:30	15:00	07:30	17:30	11.00

		1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?	N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y	4 13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	FARMINGTON CLINIC	143494	14.00
14.01		CANTON CLINIC	143492	14.01
14.02		CUBA CLINIC	143497	14.02
14.03		COLEMAN CLINIC	143493	14.03

		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/25/2012 5:44 pm
		Rural Health Clinic (RHC) I	Cost

			County					
			4.00					
2.00	City, State, Zip Code, County		FULTON					2.00
		Tuesday		Wednesday				
		from	to	from	to			
		5.00	6.00	7.00	8.00			
	Facility hours of operations (1)							
11.00	Clinic	07:30	17:30	07:30	17:30			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/25/2012 5:44 pm
		Rural Health Clinic (RHC) I	Cost

		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	17:30	07:30	17:30		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2010 To 06/30/2011	Worksheet S-8 Date/Time Prepared: 1/25/2012 5:44 pm
		Rural Health Clinic (RHC) I	Cost

		Saturday			
		from	to		
		13.00	14.00		
	Facility hours of operations (1)				
11.00	Clinic	08:30	17:00		11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140001 Component CCN: 141558	Period: From 07/01/2010 To 06/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ENROLLMENT DAYS						
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	4,204	327	0	0	622	2.00
3.00	Inpatient Respite Care	25	0	0	0	0	3.00
4.00	General Inpatient Care	21	6	0	0	3	4.00
5.00	Total Hospice Days	4,250	333	0	0	625	5.00
	Part II - CENSUS DATA						
6.00	Number of Patients Receiving Hospice Care	72	4	0	0	5	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	59.03	83.25	0.00	0.00	125.00	8.00
9.00	Unduplicated Census Count	72	4	0	0	5	9.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140001 Component CCN: 141558	Period: From 07/01/2010 To 06/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		Unduplicated Days Total (sum of cols. 1, 2 & 5)		
		6.00		
	PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0		1.00
2.00	Routine Home Care	5,153		2.00
3.00	Inpatient Respite Care	25		3.00
4.00	General Inpatient Care	30		4.00
5.00	Total Hospice Days	5,208		5.00
	Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	81		6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare			7.00
8.00	Average Length of Stay (line 5/line 6)	64.30		8.00
9.00	Unduplicated Census Count	81		9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/25/2012 5:44 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.376969	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,392,338	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	32,187,000	6.00
7.00	Medicaid cost (line 1 times line 6)	12,133,501	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)	5,741,163	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)	5,741,163	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,061,581	891,820	3,953,401	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,154,121	336,188	1,490,309	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,154,121	336,188	1,490,309	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?		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)	5,406,369	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	189,574	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	5,216,795	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,966,570	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	3,456,879	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,198,042	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT		5,530,982	5,530,982	-2,154,424	3,376,558	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB		0	0	28,512	28,512	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP		0	0	2,132,603	2,132,603	2.00
3.00	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	EMPLOYEE BENEFITS	207,549	6,892,689	7,100,238	155,808	7,256,046	4.00
5.00	ADMINISTRATIVE & GENERAL	4,861,795	5,472,045	10,333,840	-216,287	10,117,553	5.00
7.00	OPERATION OF PLANT	826,996	1,933,451	2,760,447	-4,019	2,756,428	7.00
8.00	LAUNDRY & LINEN SERVICE	22,670	248,963	271,633	0	271,633	8.00
9.00	HOUSEKEEPING	589,717	93,989	683,706	0	683,706	9.00
10.00	DIETARY	629,800	657,925	1,287,725	-709,085	578,640	10.00
11.00	CAFETERIA	0	0	0	709,085	709,085	11.00
13.00	NURSING ADMINISTRATION	478,667	11,103	489,770	0	489,770	13.00
14.00	CENTRAL SERVICES & SUPPLY	35,644	425,152	460,796	-411,718	49,078	14.00
15.00	PHARMACY	599,496	186,739	786,235	0	786,235	15.00
16.00	MEDICAL RECORDS & LIBRARY	481,197	145,836	627,033	0	627,033	16.00
20.00	NURSING SCHOOL	876,291	205,381	1,081,672	0	1,081,672	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,456,965	171,171	2,628,136	0	2,628,136	30.00
31.00	INTENSIVE CARE UNIT	503,608	41,008	544,616	0	544,616	31.00
43.00	NURSERY	246,605	11,526	258,131	0	258,131	43.00
44.00	SKILLED NURSING FACILITY	1,131,048	57,862	1,188,910	0	1,188,910	44.00
45.00	NURSING FACILITY	535,953	14,421	550,374	0	550,374	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,646,651	2,887,707	4,534,358	-2,390,135	2,144,223	50.00
52.00	DELIVERY ROOM & LABOR ROOM	66,650	0	66,650	0	66,650	52.00
53.00	ANESTHESIOLOGY	1,084,964	62,527	1,147,491	0	1,147,491	53.00
54.00	RADIOLOGY-DIAGNOSTIC	768,688	820,107	1,588,795	0	1,588,795	54.00
57.00	CT SCAN	68,597	172,277	240,874	0	240,874	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	51,758	427,787	479,545	0	479,545	58.00
60.00	LABORATORY	1,623,441	1,872,564	3,496,005	0	3,496,005	60.00
65.00	RESPIRATORY THERAPY	326,727	35,916	362,643	0	362,643	65.00
66.00	PHYSICAL THERAPY	806,081	50,730	856,811	0	856,811	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,078,103	1,078,103	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,723,750	1,723,750	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,656,383	1,656,383	0	1,656,383	73.00
76.97	CARDIAC REHABILITATION	261,476	39,390	300,866	0	300,866	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	2,626,277	7,620,344	10,246,621	-199,425	10,047,196	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	2,940,498	239,065	3,179,563	0	3,179,563	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	446,582	748,045	1,194,627	31,156	1,225,783	96.00
101.00	HOME HEALTH AGENCY	488,830	75,190	564,020	6,835	570,855	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		0	0	0	0	113.00
116.00	HOSPICE	272,685	92,148	364,833	6,835	371,668	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,963,906	38,900,423	66,864,329	-212,406	66,651,923	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	44,058	226,101	270,159	203,444	473,603	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	0	1,315	1,315	0	1,315	193.02
194.00	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	RUCHFORD POB	0	0	0	8,898	8,898	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	0	5,973	5,973	0	5,973	194.07
194.08	KELLEY HOME	0	0	0	64	64	194.08
200.00	TOTAL (SUM OF LINES 118-199)	28,007,964	39,133,812	67,141,776	0	67,141,776	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-106,692	3,269,866		1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	28,512		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-5,008	2,127,595		2.00
3.00	OTHER CAP REL COSTS	0	0		3.00
4.00	EMPLOYEE BENEFITS	-2,430,377	4,825,669		4.00
5.00	ADMINISTRATIVE & GENERAL	-1,466,116	8,651,437		5.00
7.00	OPERATION OF PLANT	0	2,756,428		7.00
8.00	LAUNDRY & LINEN SERVICE	0	271,633		8.00
9.00	HOUSEKEEPING	-4,980	678,726		9.00
10.00	DIETARY	-29,391	549,249		10.00
11.00	CAFETERIA	-396,323	312,762		11.00
13.00	NURSING ADMINISTRATION	-1,987	487,783		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	49,078		14.00
15.00	PHARMACY	-342,563	443,672		15.00
16.00	MEDICAL RECORDS & LIBRARY	-20,008	607,025		16.00
20.00	NURSING SCHOOL	-633,368	448,304		20.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-46,723	2,581,413		30.00
31.00	INTENSIVE CARE UNIT	0	544,616		31.00
43.00	NURSERY	0	258,131		43.00
44.00	SKILLED NURSING FACILITY	16,593	1,205,503		44.00
45.00	NURSING FACILITY	9,855	560,229		45.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-500	2,143,723		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	66,650		52.00
53.00	ANESTHESIOLOGY	-1,077,364	70,127		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-68,908	1,519,887		54.00
57.00	CT SCAN	0	240,874		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	479,545		58.00
60.00	LABORATORY	-115,959	3,380,046		60.00
65.00	RESPIRATORY THERAPY	0	362,643		65.00
66.00	PHYSICAL THERAPY	0	856,811		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,078,103		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,723,750		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,656,383		73.00
76.97	CARDIAC REHABILITATION	0	300,866		76.97
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC (RHC)	-97,464	9,949,732		88.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	-1,856,622	1,322,941		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	-75,963	1,149,820		96.00
101.00	HOME HEALTH AGENCY	-1,573	569,282		101.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
116.00	HOSPICE	0	371,668		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-8,751,441	57,900,482		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	473,603		192.00
193.00	NONPAID WORKERS	0	0		193.00
193.01	NONPAID WORKERS	0	0		193.01
193.02	FOUNDATION	0	1,315		193.02
194.00	PHYSICIANS CLINIC	0	0		194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0		194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0	0		194.02
194.03	RUCHFORD POB	0	8,898		194.03
194.04	GRAHAM POB	0	0		194.04
194.05	FARMINGTON POB	0	0		194.05
194.06	LEWISTON POB	0	0		194.06
194.07	OTHER RENTAL PROPERTY	0	5,973		194.07
194.08	KELLEY HOME	0	64		194.08
200.00	TOTAL (SUM OF LINES 118-199)	-8,751,441	58,390,335		200.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/25/2012 5:44 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	346,799	362,286		1.00
	TOTALS		346,799	362,286		
	B - MAINTENANCE LABOR RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	4,019	0		1.00
	TOTALS		4,019	0		
	C - OFFSITE CAPITAL RECLASS					
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	31,156		1.00
2.00	RUCHFORD POB	194.03	0	8,772		2.00
7.00	HOSPICE	116.00	0	6,835		7.00
8.00	HOME HEALTH AGENCY	101.00	0	6,835		8.00
	TOTALS		0	53,598		
	D - PROPERTY INSURANCE RECLASS					
1.00	OTHER CAP REL COSTS	3.00	0	60,289		1.00
2.00	RUCHFORD POB	194.03	0	126		2.00
6.00	KELLEY HOME	194.08	0	64		6.00
	TOTALS		0	60,479		
	E - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	28,202		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,118,272		2.00
	TOTALS		0	2,146,474		
	F - RHC EXPENSE RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	63,143	136,282		1.00
	TOTALS		63,143	136,282		
	G - EXECUTIVE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS	4.00	0	118,670		1.00
	TOTALS		0	118,670		
	H - EMPLOYEE BENEFIT AUDIT RECLASS					
1.00	EMPLOYEE BENEFITS	4.00	0	37,138		1.00
	TOTALS		0	37,138		
	I - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,723,750		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,723,750		
	J - MED SUP CHARGE TO PATIENTS RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,078,103		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,078,103		
500.00	Grand Total: Increases		413,961	5,716,780		500.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/25/2012 5:44 pm

	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	346,799	362,286	0		1.00
	TOTALS		346,799	362,286			
	B - MAINTENANCE LABOR RECLASS						
1.00	OPERATION OF PLANT	7.00	4,019	0	0		1.00
	TOTALS		4,019	0			
	C - OFFSITE CAPITAL RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	53,598	9		1.00
2.00		0.00	0	0	0		2.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	53,598			
	D - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	60,479	12		1.00
2.00		0.00	0	0	0		2.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	60,479			
	E - DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,146,474	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	2,146,474			
	F - RHC EXPENSE RECLASS						
1.00	RURAL HEALTH CLINIC (RHC)	88.00	63,143	136,282	0		1.00
	TOTALS		63,143	136,282			
	G - EXECUTIVE BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	118,670	0		1.00
	TOTALS		0	118,670			
	H - EMPLOYEE BENEFIT AUDIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	37,138	0		1.00
	TOTALS		0	37,138			
	I - IMPLANT RECLASS						
1.00	OPERATING ROOM	50.00	0	1,722,329	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,421	0		2.00
	TOTALS		0	1,723,750			
	J - MED SUP CHARGE TO PATIENTS RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	410,297	0		1.00
2.00	OPERATING ROOM	50.00	0	667,806	0		2.00
	TOTALS		0	1,078,103			
500.00	Grand Total: Decreases		413,961	5,716,780			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/25/2012 5:44 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,519,470	228,987	0	228,987	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	40,395,041	18,044,438	0	18,044,438	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	15,100,836	0	0	0	459,902	5.00
6.00	Movable Equipment	22,034,618	1,922,014	0	1,922,014	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	81,049,965	20,195,439	0	20,195,439	459,902	8.00
9.00	Reconciling Items	-11,717,614	0	0	0	-10,632,151	9.00
10.00	Total (line 8 minus line 9)	92,767,579	20,195,439	0	20,195,439	11,092,053	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	5,530,982	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,530,982	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	76,311,055	0	76,311,055	0.757163	45,648	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	517,815	0	517,815	0.005138	310	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	23,956,632	0	23,956,632	0.237699	14,331	2.00
3.00	Total (sum of lines 1-2)	100,785,502	0	100,785,502	1.000000	60,289	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/25/2012 5:44 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,748,457	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	58,439,479	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	14,640,934	0				5.00
6.00	Movable Equipment	23,956,632	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	100,785,502	0				8.00
9.00	Reconciling Items	-1,085,463	0				9.00
10.00	Total (line 8 minus line 9)	101,870,965	0				10.00

	Cost Center Description	SUMMARY OF CAPITAL					
		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	5,530,982				1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5,530,982				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	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	45,648	3,330,910	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	310	28,202	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	14,331	2,113,264	0	2.00
3.00	Total (sum of lines 1-2)	0	0	60,289	5,472,376	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-106,692	45,648	0	0	3,269,866	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	310	0	0	28,512	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	14,331	0	0	2,127,595	2.00
3.00	Total (sum of lines 1-2)	-106,692	60,289	0	0	5,425,973	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/25/2012 5:44 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - buildings and fixtures (chapter 2)	B	-106,692	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-9,149	ADMINISTRATIVE & GENERAL	5.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,086,378			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-396,323	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients	B	-337,315	PHARMACY	15.00	17.00
18.00	Sale of medical records and abstracts	B	-20,008	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	HME NON PATIENT SALES	B	-75,963	DURABLE MEDICAL EQUIP-RENTED	96.00	33.00
33.01	PHOTOCOPY REIMBURSE	B	-2	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	DIETARY CONSULTANT AND EMP PURCHASE	B	-26,574	DIETARY	10.00	33.02
33.03	NRSG SVS CPR CLASS FEES	B	-1,987	NURSING ADMINISTRATION	13.00	33.03
33.04	LAMAZE CLASS FEES	B	-123	ADULTS & PEDIATRICS	30.00	33.04
33.05	MISCELLANEOUS LAB REVENUE	B	-500	LABORATORY	60.00	33.05
33.06	MEDICAL STAFF DUES	B	-19,530	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07	REFUND/EXP REBATE	B	-5,248	PHARMACY	15.00	33.07
33.08	REFUND/EXP REBATE	B	-2,817	DIETARY	10.00	33.08
33.09	HOUSKEEPING OTHER REVENUE	B	-4,980	HOUSEKEEPING	9.00	33.09
33.10	OTHER INCOME & PURCHASE GROUP	B	-48,154	ADMINISTRATIVE & GENERAL	5.00	33.10
33.11	MISCELLANEOUS REVENUE	B	-1,578	ADMINISTRATIVE & GENERAL	5.00	33.11
33.12	MISCELLANEOUS INCOME	B	-1,172	RADIOLOGY-DIAGNOSTIC	54.00	33.12
33.13	RHC OTHER INCOME	B	-97,464	RURAL HEALTH CLINIC (RHC)	88.00	33.13
33.14			0		0.00	33.14
33.15			0		0.00	33.15
33.16			0		0.00	33.16
33.17	GHA OTHER REV OTHER REVENUE	B	-155	ADMINISTRATIVE & GENERAL	5.00	33.17
33.18	GHA SURGERY OTHER REVENUE	B	-500	OPERATING ROOM	50.00	33.18
33.19	GHA HLTHY LIV OTHER REVENUE	B	-19,518	EMPLOYEE BENEFITS	4.00	33.19

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/25/2012 5:44 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
33.20	GHA MED STAFF DUES RECEIVED	B	-200	ADMINISTRATIVE & GENERAL	5.00	33.20
33.21	GHA LAB VENDOR REBATES/REFUNDS	B	-39	LABORATORY	60.00	33.21
33.22	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)	B	-633,368	NURSING SCHOOL	20.00	33.22
34.00	DONATIONS & DUES	A	-10,400	ADMINISTRATIVE & GENERAL	5.00	34.00
34.01	CRNA SALARY EXPENSE	A	-1,084,964	ANESTHESIOLOGY	53.00	34.01
34.02	CRNA BENEFIT EXPENSE	A	-24,854	EMPLOYEE BENEFITS	4.00	34.02
34.03	CRNA CONTRACTED EXPENSE	A	7,600	ANESTHESIOLOGY	53.00	34.03
34.04	UNEMPLOYMENT CASH BASIS	A	-49,719	EMPLOYEE BENEFITS	4.00	34.04
34.05	IL PROVIDER PARTICIPATION FEE	A	17,520	SKILLED NURSING FACILITY	44.00	34.05
34.06	IL PROVIDER PARTICIPATION FEE	A	9,855	NURSING FACILITY	45.00	34.06
34.07	IL HOSPITAL PROVIDER TAX	A	-981,347	ADMINISTRATIVE & GENERAL	5.00	34.07
34.08	TELEVISION AND RADIO SERVICE	A	-825	NEW CAP REL COSTS-MVBLE EQUIP	2.00	34.08
34.09	PHONE SALARIES EXPENSE	A	-5,507	ADMINISTRATIVE & GENERAL	5.00	34.09
35.00	PHONE BENEFIT EXPENSE	A	-872	EMPLOYEE BENEFITS	4.00	35.00
36.00			0		0.00	36.00
37.00	PHONE DEPREPATION M/M EXPENSE	A	-2,196	NEW CAP REL COSTS-MVBLE EQUIP	2.00	37.00
38.00	IHA & AHA DUES LOBBYING PORTION	A	-24,825	ADMINISTRATIVE & GENERAL	5.00	38.00
39.00	IL HEALTHCARE ASSOCIATION LOBBYING	A	-927	SKILLED NURSING FACILITY	44.00	39.00
40.00	IL HOMECARE COUNCIL LOBBYING	A	-1,573	HOME HEALTH AGENCY	101.00	40.00
42.00	MARKETING DEPT SALARY EXPENSE	A	-104,127	ADMINISTRATIVE & GENERAL	5.00	42.00
43.00	MARKETING DEPT BENEIFT EXPENSE	A	-9,939	EMPLOYEE BENEFITS	4.00	43.00
44.00	MARKETING DEPT OTHER EXPENSE	A	-259,196	ADMINISTRATIVE & GENERAL	5.00	44.00
45.00	MARKETING DEPRECIATION EXPENSE	A	-1,987	NEW CAP REL COSTS-MVBLE EQUIP	2.00	45.00
45.01	INVST INCOME-NEW BLDGS AND FIXTURES	A	-1,946	ADMINISTRATIVE & GENERAL	5.00	45.01
45.02	LOAN FORGIVENESS EXPENSE	A	-270,865	EMPLOYEE BENEFITS	4.00	45.02
45.03	ER PHYSICIAN BENEFITS	A	-29,084	EMPLOYEE BENEFITS	4.00	45.03
45.04	SELF INSURANCE COSTS	A	-2,025,526	EMPLOYEE BENEFITS	4.00	45.04
45.05			0		0.00	45.05
45.07			0		0.00	45.07
45.08			0		0.00	45.08
45.09			0		0.00	45.09
45.10			0		0.00	45.10
45.11			0		0.00	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,751,441			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/25/2012 5:44 pm

		Wkst. A-7 Ref. 5.00		
1.00	Investment income - buildings and fixtures (chapter 2)	11		1.00
2.00	Investment income - movable equipment (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	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 - buildings and fixtures	0		26.00
27.00	Depreciation - movable equipment	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	HME NON PATIENT SALES	0		33.00
33.01	PHOTOCOPY REIMBURSE	0		33.01
33.02	DIETARY CONSULTANT AND EMP PURCHASE	0		33.02
33.03	NRSG SVS CPR CLASS FEES	0		33.03
33.04	LAMAZE CLASS FEES	0		33.04
33.05	MISCELLANEOUS LAB REVENUE	0		33.05
33.06	MEDICAL STAFF DUES	0		33.06
33.07	REFUND/EXP REBATE	0		33.07
33.08	REFUND/EXP REBATE	0		33.08
33.09	HOUSKEEPING OTHER REVENUE	0		33.09
33.10	OTHER INCOME & PURCHASE GROUP	0		33.10
33.11	MISCELLANEOUS REVENUE	0		33.11
33.12	MISCELLANEOUS INCOME	0		33.12
33.13	RHC OTHER INCOME	0		33.13
33.14		0		33.14
33.15		0		33.15
33.16		0		33.16
33.17	GHA OTHER REV OTHER REVENUE	0		33.17
33.18	GHA SURGERY OTHER REVENUE	0		33.18
33.19	GHA HLTHY LIV OTHER REVENUE	0		33.19
33.20	GHA MED STAFF DUES RECEIVED	0		33.20
33.21	GHA LAB VENDOR REBATES/REFUNDS	0		33.21
33.22	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)	0		33.22
34.00	DONATIONS & DUES	0		34.00
34.01	CRNA SALARY EXPENSE	0		34.01
34.02	CRNA BENEFIT EXPENSE	0		34.02
34.03	CRNA CONTRACTED EXPENSE	0		34.03
34.04	UNEMPLOYMENT CASH BASIS	0		34.04

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/25/2012 5:44 pm

		Wkst. A-7 Ref. 5.00		
34.05	IL PROVIDER PARTICIPATION FEE	0		34.05
34.06	IL PROVIDER PARTICIPATION FEE	0		34.06
34.07	IL HOSPITAL PROVIDER TAX	0		34.07
34.08	TELEVISION AND RADIO SERVICE	9		34.08
34.09	PHONE SALARIES EXPENSE	0		34.09
35.00	PHONE BENEFIT EXPENSE	0		35.00
36.00		0		36.00
37.00	PHONE DEPREPATION M/M EXPENSE	9		37.00
38.00	IHA & AHA DUES LOBBYING PORTION	0		38.00
39.00	IL HEALTHCARE ASSOCIATION LOBBYING	0		39.00
40.00	IL HOMECARE COUNCIL LOBBYING	0		40.00
42.00	MARKETING DEPT SALARY EXPENSE	0		42.00
43.00	MARKETING DEPT BENEIFT EXPENSE	0		43.00
44.00	MARKETING DEPT OTHER EXPENSE	0		44.00
45.00	MARKETING DEPRECIATION EXPENSE	9		45.00
45.01	INVST INCOME-NEW BLDGS AND FIXTURES	0		45.01
45.02	LOAN FORGIVENESS EXPENSE	0		45.02
45.03	ER PHYSICIAN BENEFITS	0		45.03
45.04	SELF INSURANCE COSTS	0		45.04
45.05		0		45.05
45.07		0		45.07
45.08		0		45.08
45.09		0		45.09
45.10		0		45.10
45.11		0		45.11
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: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/25/2012 5:44 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	1,867,762	1,836,757	1.00
2.00		60.00	LABORATORY	57,000	57,000	2.00
3.00		60.00	LABORATORY	58,420	58,420	3.00
4.00		54.00	MAMMOGRAM	6,306	6,306	4.00
5.00		54.00	ECHO	61,430	61,430	5.00
6.00		0.00		0	0	6.00
7.00		30.00	OB	46,600	46,600	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00			TOTAL (lines 1.00 through 199.00)	2,097,518	2,066,513	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/25/2012 5:44 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		31,005	159,800	145	11,140	557	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		31,005		145	11,140	557	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/25/2012 5:44 pm

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	0	0	11,140	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	11,140	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/25/2012 5:44 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		19,865	1,856,622		1.00
2.00		0	57,000		2.00
3.00		0	58,420		3.00
4.00		0	6,306		4.00
5.00		0	61,430		5.00
6.00		0	0		6.00
7.00		0	46,600		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		19,865	2,086,378		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	NEW CARDIAC REHAB	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	
		0	1.00	1.01	2.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,269,866	3,269,866				1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	28,512	0	28,512			1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,127,595			2,127,595		2.00
4.00	EMPLOYEE BENEFITS	4,825,669	19,394	0	2,095	4,847,158	4.00
5.00	ADMINISTRATIVE & GENERAL	8,651,437	334,823	0	534,191	935,690	5.00
7.00	OPERATION OF PLANT	2,756,428	418,900	0	16,681	162,042	7.00
8.00	LAUNDRY & LINEN SERVICE	271,633	52,001	0	0	4,464	8.00
9.00	HOUSEKEEPING	678,726	40,588	0	9,174	116,114	9.00
10.00	DIETARY	549,249	114,356	0	28,976	55,722	10.00
11.00	CAFETERIA	312,762	30,576	0	0	68,284	11.00
13.00	NURSING ADMINISTRATION	487,783	34,903	0	3,562	94,248	13.00
14.00	CENTRAL SERVICES & SUPPLY	49,078	0	0	2,660	7,018	14.00
15.00	PHARMACY	443,672	26,139	0	56,174	118,039	15.00
16.00	MEDICAL RECORDS & LIBRARY	607,025	60,467	0	77,228	94,746	16.00
20.00	NURSING SCHOOL	448,304	341,457	0	17,944	172,539	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,581,413	235,589	0	99,262	483,769	30.00
31.00	INTENSIVE CARE UNIT	544,616	41,095	0	5,418	99,159	31.00
43.00	NURSERY	258,131	11,921	0	3,277	48,556	43.00
44.00	SKILLED NURSING FACILITY	1,205,503	159,613	0	12,622	222,700	44.00
45.00	NURSING FACILITY	560,229	71,903	0	11,180	105,528	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,143,723	192,231	0	336,897	324,221	50.00
52.00	DELIVERY ROOM & LABOR ROOM	66,650	35,322	0	356	13,123	52.00
53.00	ANESTHESIOLOGY	70,127	13,908	0	31,948	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,519,887	118,098	0	362,686	151,352	54.00
57.00	CT SCAN	240,874	0	0	78,660	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	479,545	32,728	0	72,363	0	58.00
60.00	LABORATORY	3,380,046	160,054	0	92,156	319,651	60.00
65.00	RESPIRATORY THERAPY	362,643	2,141	0	11,334	64,332	65.00
66.00	PHYSICAL THERAPY	856,811	47,939	0	3,911	158,715	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,078,103	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,723,750	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,656,383	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	300,866	0	28,512	15,617	51,484	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	9,949,732	326,125	0	56,799	504,673	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,322,941	127,790	0	103,964	211,219	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	1,149,820	0	0	35,680	87,931	96.00
101.00	HOME HEALTH AGENCY	569,282	0	0	30,628	96,249	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	371,668	0	0	8,370	53,691	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	57,900,482	3,050,061	28,512	2,121,813	4,825,259	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,290	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	473,603	122,072	0	5,782	21,899	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	1,315	0	0	0	0	193.02
194.00	PHYSICIANS CLINIC	0	33,667	0	0	0	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0	50,776	0	0	0	194.02
194.03	RUCHFORD POB	8,898	0	0	0	0	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	5,973	0	0	0	0	194.07
194.08	KELLEY HOME	64	0	0	0	0	194.08
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)	58,390,335	3,269,866	28,512	2,127,595	4,847,158	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	10,456,141	10,456,141				5.00
7.00	OPERATION OF PLANT	3,354,051	731,636	4,085,687			7.00
8.00	LAUNDRY & LINEN SERVICE	328,098	71,570	85,095	484,763		8.00
9.00	HOUSEKEEPING	844,602	184,237	66,418	0	1,095,257	9.00
10.00	DIETARY	748,303	163,231	187,133	0	0	10.00
11.00	CAFETERIA	411,622	89,789	50,034	0	0	11.00
13.00	NURSING ADMINISTRATION	620,496	135,352	57,115	0	8,334	13.00
14.00	CENTRAL SERVICES & SUPPLY	58,756	12,817	0	0	0	14.00
15.00	PHARMACY	644,024	140,484	42,773	0	6,747	15.00
16.00	MEDICAL RECORDS & LIBRARY	839,466	183,117	98,949	0	7,540	16.00
20.00	NURSING SCHOOL	980,244	213,826	558,760	521	16,091	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,400,033	741,666	385,519	155,448	315,647	30.00
31.00	INTENSIVE CARE UNIT	690,288	150,576	67,249	17,144	28,285	31.00
43.00	NURSERY	321,885	70,214	19,508	1,501	0	43.00
44.00	SKILLED NURSING FACILITY	1,600,438	349,112	261,191	87,625	110,868	44.00
45.00	NURSING FACILITY	748,840	163,348	117,662	50,139	98,313	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,997,072	653,766	314,567	76,172	193,017	50.00
52.00	DELIVERY ROOM & LABOR ROOM	115,451	25,184	57,802	0	0	52.00
53.00	ANESTHESIOLOGY	115,983	25,300	22,759	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,152,023	469,432	193,256	21,771	46,865	54.00
57.00	CT SCAN	319,534	69,702	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	584,636	127,530	53,557	2,074	0	58.00
60.00	LABORATORY	3,951,907	862,049	261,913	2,241	43,510	60.00
65.00	RESPIRATORY THERAPY	440,450	96,078	3,504	0	13,746	65.00
66.00	PHYSICAL THERAPY	1,067,376	232,832	78,448	9,265	11,617	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,078,103	235,172	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,723,750	376,010	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,656,383	361,315	0	0	0	73.00
76.97	CARDIAC REHABILITATION	396,479	86,486	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	10,837,329	2,364,014	533,671	0	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,765,914	385,208	209,115	57,892	133,777	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	1,273,431	277,780	0	0	0	96.00
101.00	HOME HEALTH AGENCY	696,159	151,857	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	433,729	94,611	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	57,652,996	10,295,301	3,725,998	481,793	1,034,357	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,290	2,899	21,748	0	15,369	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	623,356	135,976	199,759	2,261	30,017	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	1,315	287	0	0	0	193.02
194.00	PHYSICIANS CLINIC	33,667	7,344	55,092	0	0	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	50,776	11,076	83,090	709	15,514	194.02
194.03	RUCHFORD POB	8,898	1,941	0	0	0	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	5,973	1,303	0	0	0	194.07
194.08	KELLEY HOME	64	14	0	0	0	194.08
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)	58,390,335	10,456,141	4,085,687	484,763	1,095,257	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	1,098,667					10.00
11.00	CAFETERIA	0	551,445				11.00
13.00	NURSING ADMINISTRATION	0	13,557	834,854			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	2,545	0	74,118		14.00
15.00	PHARMACY	0	20,945	0	1,091	856,064	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	31,267	0	0	0	16.00
20.00	NURSING SCHOOL	0	28,510	0	63	63	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	377,786	85,970	646,612	796	621	30.00
31.00	INTENSIVE CARE UNIT	28,701	14,511	109,143	72	132	31.00
43.00	NURSERY	0	8,131	61,152	157	5	43.00
44.00	SKILLED NURSING FACILITY	375,021	52,460	0	298	107	44.00
45.00	NURSING FACILITY	317,159	29,942	0	53	28	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	55,146	0	1,050	8,581	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	2,386	17,947	0	0	52.00
53.00	ANESTHESIOLOGY	0	8,838	0	122	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	27,732	0	124	2,628	54.00
57.00	CT SCAN	0	2,351	0	0	38	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	1,874	0	0	0	58.00
60.00	LABORATORY	0	70,842	0	622	383	60.00
65.00	RESPIRATORY THERAPY	0	13,044	0	279	851	65.00
66.00	PHYSICAL THERAPY	0	25,417	0	75	38	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,240	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	40,164	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	670,425	73.00
76.97	CARDIAC REHABILITATION	0	10,287	0	49	232	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	0	0	2,676	125,586	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	45,690	0	816	1,830	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	1,747	96.00
101.00	HOME HEALTH AGENCY	0	0	0	313	493	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	7	42,270	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,098,667	551,445	834,854	74,067	856,058	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	51	6	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	0	0	0	0	0	193.02
194.00	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	RUCHFORD POB	0	0	0	0	0	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	KELLEY HOME	0	0	0	0	0	194.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,098,667	551,445	834,854	74,118	856,064	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	20.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY	1,160,339					16.00
20.00	NURSING SCHOOL	0	1,798,078				20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	322,017	835,385	7,267,500	0	7,267,500	30.00
31.00	INTENSIVE CARE UNIT	20,584	67,971	1,194,656	0	1,194,656	31.00
43.00	NURSERY	13,759	0	496,312	0	496,312	43.00
44.00	SKILLED NURSING FACILITY	45,221	296,551	3,178,892	0	3,178,892	44.00
45.00	NURSING FACILITY	38,250	0	1,563,734	0	1,563,734	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	75,959	179,383	4,554,713	0	4,554,713	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	218,770	0	218,770	52.00
53.00	ANESTHESIOLOGY	0	0	173,002	0	173,002	53.00
54.00	RADIOLOGY-DIAGNOSTIC	327,008	16,079	3,256,918	0	3,256,918	54.00
57.00	CT SCAN	0	0	391,625	0	391,625	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	769,671	0	769,671	58.00
60.00	LABORATORY	134,628	28,504	5,356,599	0	5,356,599	60.00
65.00	RESPIRATORY THERAPY	0	0	567,952	0	567,952	65.00
66.00	PHYSICAL THERAPY	0	11,054	1,436,122	0	1,436,122	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,338,515	0	1,338,515	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	2,139,924	0	2,139,924	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	2,688,123	0	2,688,123	73.00
76.97	CARDIAC REHABILITATION	0	29,600	523,133	0	523,133	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	56,277	13,919,553	0	13,919,553	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	182,913	76,833	2,859,988	0	2,859,988	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	1,552,958	0	1,552,958	96.00
101.00	HOME HEALTH AGENCY	0	63,220	912,042	0	912,042	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	34,716	605,333	0	605,333	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,160,339	1,695,573	56,966,035	0	56,966,035	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	53,306	0	53,306	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	102,505	1,093,931	0	1,093,931	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	0	0	1,602	0	1,602	193.02
194.00	PHYSICIANS CLINIC	0	0	96,103	0	96,103	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0	0	161,165	0	161,165	194.02
194.03	RUCHFORD POB	0	0	10,839	0	10,839	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	0	0	7,276	0	7,276	194.07
194.08	KELLEY HOME	0	0	78	0	78	194.08
200.00	Cross Foot Adjustments		0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,160,339	1,798,078	58,390,335	0	58,390,335	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW CARDIAC REHAB	NEW MVBLE EQUIP	Subtotal	
		0	1.00	1.01	2.00	2A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	19,394	0	2,095	21,489	4.00
5.00	ADMINISTRATIVE & GENERAL	0	334,823	0	534,191	869,014	5.00
7.00	OPERATION OF PLANT	3,002	418,900	0	16,681	438,583	7.00
8.00	LAUNDRY & LINEN SERVICE	0	52,001	0	0	52,001	8.00
9.00	HOUSEKEEPING	3,028	40,588	0	9,174	52,790	9.00
10.00	DIETARY	0	114,356	0	28,976	143,332	10.00
11.00	CAFETERIA	0	30,576	0	0	30,576	11.00
13.00	NURSING ADMINISTRATION	0	34,903	0	3,562	38,465	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,028	0	0	2,660	3,688	14.00
15.00	PHARMACY	0	26,139	0	56,174	82,313	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	60,467	0	77,228	137,695	16.00
20.00	NURSING SCHOOL	0	341,457	0	17,944	359,401	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	235,589	0	99,262	334,851	30.00
31.00	INTENSIVE CARE UNIT	0	41,095	0	5,418	46,513	31.00
43.00	NURSERY	0	11,921	0	3,277	15,198	43.00
44.00	SKILLED NURSING FACILITY	0	159,613	0	12,622	172,235	44.00
45.00	NURSING FACILITY	0	71,903	0	11,180	83,083	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	192,231	0	336,897	529,128	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	35,322	0	356	35,678	52.00
53.00	ANESTHESIOLOGY	1,242	13,908	0	31,948	47,098	53.00
54.00	RADIOLOGY-DIAGNOSTIC	355,633	118,098	0	362,686	836,417	54.00
57.00	CT SCAN	0	0	0	78,660	78,660	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	32,728	0	72,363	105,091	58.00
60.00	LABORATORY	0	160,054	0	92,156	252,210	60.00
65.00	RESPIRATORY THERAPY	3,605	2,141	0	11,334	17,080	65.00
66.00	PHYSICAL THERAPY	0	47,939	0	3,911	51,850	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	28,512	15,617	44,129	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	326,125	0	56,799	382,924	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	127,790	0	103,964	231,754	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	31,156	0	0	35,680	66,836	96.00
101.00	HOME HEALTH AGENCY	6,835	0	0	30,628	37,463	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	60,389	0	0	8,370	68,759	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	465,918	3,050,061	28,512	2,121,813	5,666,304	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,290	0	0	13,290	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	122,072	0	5,782	127,854	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	0	0	0	0	0	193.02
194.00	PHYSICIANS CLINIC	0	33,667	0	0	33,667	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0	50,776	0	0	50,776	194.02
194.03	RUCHFORD POB	8,772	0	0	0	8,772	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	KELLEY HOME	0	0	0	0	0	194.08
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	474,690	3,269,866	28,512	2,127,595	5,900,663	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	21,489					4.00
5.00	ADMINISTRATIVE & GENERAL	4,147	873,161				5.00
7.00	OPERATION OF PLANT	718	61,097	500,398			7.00
8.00	LAUNDRY & LINEN SERVICE	20	5,977	10,422	68,420		8.00
9.00	HOUSEKEEPING	515	15,385	8,135	0	76,825	9.00
10.00	DIETARY	247	13,631	22,919	0	0	10.00
11.00	CAFETERIA	303	7,498	6,128	0	0	11.00
13.00	NURSING ADMINISTRATION	418	11,303	6,995	0	585	13.00
14.00	CENTRAL SERVICES & SUPPLY	31	1,070	0	0	0	14.00
15.00	PHARMACY	523	11,732	5,239	0	473	15.00
16.00	MEDICAL RECORDS & LIBRARY	420	15,292	12,119	0	529	16.00
20.00	NURSING SCHOOL	765	17,856	68,435	74	1,129	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,145	61,935	47,217	21,938	22,140	30.00
31.00	INTENSIVE CARE UNIT	440	12,574	8,236	2,420	1,984	31.00
43.00	NURSERY	215	5,863	2,389	212	0	43.00
44.00	SKILLED NURSING FACILITY	987	29,154	31,990	12,368	7,777	44.00
45.00	NURSING FACILITY	468	13,641	14,411	7,077	6,896	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,438	54,595	38,527	10,751	13,539	50.00
52.00	DELIVERY ROOM & LABOR ROOM	58	2,103	7,079	0	0	52.00
53.00	ANESTHESIOLOGY	0	2,113	2,787	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	671	39,201	23,669	3,073	3,287	54.00
57.00	CT SCAN	0	5,821	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	10,650	6,559	293	0	58.00
60.00	LABORATORY	1,417	71,988	32,078	316	3,052	60.00
65.00	RESPIRATORY THERAPY	285	8,023	429	0	964	65.00
66.00	PHYSICAL THERAPY	704	19,443	9,608	1,308	815	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,639	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	31,400	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	30,173	0	0	0	73.00
76.97	CARDIAC REHABILITATION	228	7,222	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	2,238	197,404	65,362	0	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	936	32,168	25,612	8,171	9,384	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	390	23,197	0	0	0	96.00
101.00	HOME HEALTH AGENCY	427	12,681	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	238	7,901	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,392	859,730	456,345	68,001	72,554	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	242	2,664	0	1,078	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	97	11,355	24,466	319	2,105	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	0	24	0	0	0	193.02
194.00	PHYSICIANS CLINIC	0	613	6,747	0	0	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0	925	10,176	100	1,088	194.02
194.03	RUCHFORD POB	0	162	0	0	0	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	0	109	0	0	0	194.07
194.08	KELLEY HOME	0	1	0	0	0	194.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	21,489	873,161	500,398	68,420	76,825	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	180,129					10.00
11.00	CAFETERIA	0	44,505				11.00
13.00	NURSING ADMINISTRATION	0	1,094	58,860			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	205	0	4,994		14.00
15.00	PHARMACY	0	1,690	0	74	102,044	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	2,523	0	0	0	16.00
20.00	NURSING SCHOOL	0	2,301	0	4	8	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	61,938	6,941	45,589	54	74	30.00
31.00	INTENSIVE CARE UNIT	4,706	1,171	7,695	5	16	31.00
43.00	NURSERY	0	656	4,311	11	1	43.00
44.00	SKILLED NURSING FACILITY	61,486	4,234	0	20	13	44.00
45.00	NURSING FACILITY	51,999	2,416	0	4	3	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	4,451	0	71	1,023	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	193	1,265	0	0	52.00
53.00	ANESTHESIOLOGY	0	713	0	8	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,238	0	8	313	54.00
57.00	CT SCAN	0	190	0	0	5	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	151	0	0	0	58.00
60.00	LABORATORY	0	5,717	0	42	46	60.00
65.00	RESPIRATORY THERAPY	0	1,053	0	19	101	65.00
66.00	PHYSICAL THERAPY	0	2,051	0	5	5	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,701	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,706	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	79,913	73.00
76.97	CARDIAC REHABILITATION	0	830	0	3	28	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	0	0	180	14,970	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	3,687	0	55	218	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	208	96.00
101.00	HOME HEALTH AGENCY	0	0	0	21	59	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	0	5,039	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	180,129	44,505	58,860	4,991	102,043	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	3	1	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	0	0	0	0	0	193.02
194.00	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	RUCHFORD POB	0	0	0	0	0	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	KELLEY HOME	0	0	0	0	0	194.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	180,129	44,505	58,860	4,994	102,044	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	20.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY	168,578					16.00
20.00	NURSING SCHOOL	0	449,973				20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	46,784		651,606	0	651,606	30.00
31.00	INTENSIVE CARE UNIT	2,990		88,750	0	88,750	31.00
43.00	NURSERY	1,999		30,855	0	30,855	43.00
44.00	SKILLED NURSING FACILITY	6,570		326,834	0	326,834	44.00
45.00	NURSING FACILITY	5,557		185,555	0	185,555	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	11,036		664,559	0	664,559	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0		46,376	0	46,376	52.00
53.00	ANESTHESIOLOGY	0		52,719	0	52,719	53.00
54.00	RADIOLOGY-DIAGNOSTIC	47,509		956,386	0	956,386	54.00
57.00	CT SCAN	0		84,676	0	84,676	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		122,744	0	122,744	58.00
60.00	LABORATORY	19,559		386,425	0	386,425	60.00
65.00	RESPIRATORY THERAPY	0		27,954	0	27,954	65.00
66.00	PHYSICAL THERAPY	0		85,789	0	85,789	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		21,340	0	21,340	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0		34,106	0	34,106	72.00
73.00	DRUGS CHARGED TO PATIENTS	0		110,086	0	110,086	73.00
76.97	CARDIAC REHABILITATION	0		52,440	0	52,440	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0		663,078	0	663,078	88.00
90.00	CLINIC	0		0	0	0	90.00
91.00	EMERGENCY	26,574		338,559	0	338,559	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0		90,631	0	90,631	96.00
101.00	HOME HEALTH AGENCY	0		50,651	0	50,651	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0		0	0	0	113.00
116.00	HOSPICE	0		81,937	0	81,937	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	168,578	0	5,154,056	0	5,154,056	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		17,274	0	17,274	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0		166,200	0	166,200	192.00
193.00	NONPAID WORKERS	0		0	0	0	193.00
193.01	NONPAID WORKERS	0		0	0	0	193.01
193.02	FOUNDATION	0		24	0	24	193.02
194.00	PHYSICIANS CLINIC	0		41,027	0	41,027	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0		0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0		63,065	0	63,065	194.02
194.03	RUCHFORD POB	0		8,934	0	8,934	194.03
194.04	GRAHAM POB	0		0	0	0	194.04
194.05	FARMINGTON POB	0		0	0	0	194.05
194.06	LEWISTON POB	0		0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	0		109	0	109	194.07
194.08	KELLEY HOME	0		1	0	1	194.08
200.00	Cross Foot Adjustments		449,973	449,973	0	449,973	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	168,578	449,973	5,900,663	0	5,900,663	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00	4.00	5A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	296,231					1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	30,653				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2,118,271			2.00
4.00	EMPLOYEE BENEFITS	1,757	0	2,086	24,617,700		4.00
5.00	ADMINISTRATIVE & GENERAL	30,333	0	531,851	4,752,161	-10,456,141	5.00
7.00	OPERATION OF PLANT	37,950	0	16,608	822,977	0	7.00
8.00	LAUNDRY & LINEN SERVICE	4,711	0	0	22,670	0	8.00
9.00	HOUSEKEEPING	3,677	0	9,134	589,717	0	9.00
10.00	DIETARY	10,360	0	28,849	283,001	0	10.00
11.00	CAFETERIA	2,770	0	0	346,799	0	11.00
13.00	NURSING ADMINISTRATION	3,162	0	3,546	478,667	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	2,648	35,644	0	14.00
15.00	PHARMACY	2,368	0	55,928	599,496	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	5,478	0	76,890	481,197	0	16.00
20.00	NURSING SCHOOL	30,934	0	17,865	876,291	0	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	21,343	0	98,827	2,456,965	0	30.00
31.00	INTENSIVE CARE UNIT	3,723	0	5,394	503,608	0	31.00
43.00	NURSERY	1,080	0	3,263	246,605	0	43.00
44.00	SKILLED NURSING FACILITY	14,460	0	12,567	1,131,048	0	44.00
45.00	NURSING FACILITY	6,514	0	11,131	535,953	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	17,415	0	335,420	1,646,651	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	3,200	0	354	66,650	0	52.00
53.00	ANESTHESIOLOGY	1,260	0	31,808	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	10,699	0	361,096	768,688	0	54.00
57.00	CT SCAN	0	0	78,315	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	2,965	0	72,046	0	0	58.00
60.00	LABORATORY	14,500	0	91,752	1,623,441	0	60.00
65.00	RESPIRATORY THERAPY	194	0	11,284	326,727	0	65.00
66.00	PHYSICAL THERAPY	4,343	0	3,894	806,081	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	30,653	15,549	261,476	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	29,545	0	56,550	2,563,134	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	11,577	0	103,508	1,072,736	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	35,524	446,582	0	96.00
101.00	HOME HEALTH AGENCY	0	0	30,494	488,830	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	8,333	272,685	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	276,318	30,653	2,112,514	24,506,480	-10,456,141	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,204	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	11,059	0	5,757	111,220	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	0	0	0	0	0	193.02
194.00	PHYSICIANS CLINIC	3,050	0	0	0	0	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	4,600	0	0	0	0	194.02
194.03	RUCHFORD POB	0	0	0	0	0	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	KELLEY HOME	0	0	0	0	0	194.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,269,866	28,512	2,127,595	4,847,158		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.038230	0.930154	1.004402	0.196897		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				21,489		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000873		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	47,934,194					5.00
7.00	OPERATION OF PLANT	3,354,051	226,191				7.00
8.00	LAUNDRY & LINEN SERVICE	328,098	4,711	1,209,390			8.00
9.00	HOUSEKEEPING	844,602	3,677	0	30,358		9.00
10.00	DIETARY	748,303	10,360	0	0	66,760	10.00
11.00	CAFETERIA	411,622	2,770	0	0	0	11.00
13.00	NURSING ADMINISTRATION	620,496	3,162	0	231	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	58,756	0	0	0	0	14.00
15.00	PHARMACY	644,024	2,368	0	187	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	839,466	5,478	0	209	0	16.00
20.00	NURSING SCHOOL	980,244	30,934	1,300	446	0	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,400,033	21,343	387,816	8,749	22,956	30.00
31.00	INTENSIVE CARE UNIT	690,288	3,723	42,770	784	1,744	31.00
43.00	NURSERY	321,885	1,080	3,744	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,600,438	14,460	218,608	3,073	22,788	44.00
45.00	NURSING FACILITY	748,840	6,514	125,086	2,725	19,272	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,997,072	17,415	190,034	5,350	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	115,451	3,200	0	0	0	52.00
53.00	ANESTHESIOLOGY	115,983	1,260	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,152,023	10,699	54,314	1,299	0	54.00
57.00	CT SCAN	319,534	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	584,636	2,965	5,174	0	0	58.00
60.00	LABORATORY	3,951,907	14,500	5,590	1,206	0	60.00
65.00	RESPIRATORY THERAPY	440,450	194	0	381	0	65.00
66.00	PHYSICAL THERAPY	1,067,376	4,343	23,114	322	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,078,103	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,723,750	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,656,383	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	396,479	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	10,837,329	29,545	0	0	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,765,914	11,577	144,430	3,708	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	1,273,431	0	0	0	0	96.00
101.00	HOME HEALTH AGENCY	696,159	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	433,729	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	47,196,855	206,278	1,201,980	28,670	66,760	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,290	1,204	0	426	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	623,356	11,059	5,642	832	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	1,315	0	0	0	0	193.02
194.00	PHYSICIANS CLINIC	33,667	3,050	0	0	0	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	50,776	4,600	1,768	430	0	194.02
194.03	RUCHFORD POB	8,898	0	0	0	0	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	5,973	0	0	0	0	194.07
194.08	KELLEY HOME	64	0	0	0	0	194.08
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)	10,456,141	4,085,687	484,763	1,095,257	1,098,667	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.218135	18.062995	0.400833	36.078035	16.456965	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	873,161	500,398	68,420	76,825	180,129	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.018216	2.212281	0.056574	2.530634	2.698158	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	31,199					11.00
13.00	NURSING ADMINISTRATION	767	6,280				13.00
14.00	CENTRAL SERVICES & SUPPLY	144	0	3,180,916			14.00
15.00	PHARMACY	1,185	0	46,839	2,025,137		15.00
16.00	MEDICAL RECORDS & LIBRARY	1,769	0	0	0	126,499	16.00
20.00	NURSING SCHOOL	1,613	0	2,687	150	0	20.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,864	4,864	34,163	1,468	35,106	30.00
31.00	INTENSIVE CARE UNIT	821	821	3,090	312	2,244	31.00
43.00	NURSERY	460	460	6,744	11	1,500	43.00
44.00	SKILLED NURSING FACILITY	2,968	0	12,810	252	4,930	44.00
45.00	NURSING FACILITY	1,694	0	2,273	66	4,170	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,120	0	45,060	20,299	8,281	50.00
52.00	DELIVERY ROOM & LABOR ROOM	135	135	0	0	0	52.00
53.00	ANESTHESIOLOGY	500	0	5,226	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,569	0	5,316	6,218	35,650	54.00
57.00	CT SCAN	133	0	0	91	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	106	0	0	1	0	58.00
60.00	LABORATORY	4,008	0	26,709	907	14,677	60.00
65.00	RESPIRATORY THERAPY	738	0	11,981	2,012	0	65.00
66.00	PHYSICAL THERAPY	1,438	0	3,202	90	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,083,214	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	1,723,750	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	1,585,985	0	73.00
76.97	CARDIAC REHABILITATION	582	0	2,085	548	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	0	114,832	297,090	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	2,585	0	35,024	4,329	19,941	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	4,132	0	96.00
101.00	HOME HEALTH AGENCY	0	0	13,431	1,166	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	285	99,995	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,199	6,280	3,178,721	2,025,122	126,499	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	2,195	15	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	FOUNDATION	0	0	0	0	0	193.02
194.00	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	RUCHFORD POB	0	0	0	0	0	194.03
194.04	GRAHAM POB	0	0	0	0	0	194.04
194.05	FARMINGTON POB	0	0	0	0	0	194.05
194.06	LEWISTON POB	0	0	0	0	0	194.06
194.07	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	KELLEY HOME	0	0	0	0	0	194.08
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)	551,445	834,854	74,118	856,064	1,160,339	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.675086	132.938535	0.023301	0.422719	9.172713	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	44,505	58,860	4,994	102,044	168,578	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.426488	9.372611	0.001570	0.050389	1.332643	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	NURSING SCHOOL (ASSIGNED TIME) 20.00		
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB			1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
20.00	NURSING SCHOOL	984,075		20.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	457,200		30.00
31.00	INTENSIVE CARE UNIT	37,200		31.00
43.00	NURSERY	0		43.00
44.00	SKILLED NURSING FACILITY	162,300		44.00
45.00	NURSING FACILITY	0		45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	98,175		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	ANESTHESIOLOGY	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	8,800		54.00
57.00	CT SCAN	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
60.00	LABORATORY	15,600		60.00
65.00	RESPIRATORY THERAPY	0		65.00
66.00	PHYSICAL THERAPY	6,050		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0		73.00
76.97	CARDIAC REHABILITATION	16,200		76.97
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC (RHC)	30,800		88.00
90.00	CLINIC	0		90.00
91.00	EMERGENCY	42,050		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS			
96.00	DURABLE MEDICAL EQUIP-RENTED	0		96.00
101.00	HOME HEALTH AGENCY	34,600		101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	0		113.00
116.00	HOSPICE	19,000		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	927,975		118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	56,100		192.00
193.00	NONPAID WORKERS	0		193.00
193.01	NONPAID WORKERS	0		193.01
193.02	FOUNDATION	0		193.02
194.00	PHYSICIANS CLINIC	0		194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	0		194.01
194.02	ST. FRANCIS RENAL DIALYSIS	0		194.02
194.03	RUCHFORD POB	0		194.03
194.04	GRAHAM POB	0		194.04
194.05	FARMINGTON POB	0		194.05
194.06	LEWISTON POB	0		194.06
194.07	OTHER RENTAL PROPERTY	0		194.07
194.08	KELLEY HOME	0		194.08
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,798,078		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.827176		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	449,973		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.457255		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/25/2012 5:44 pm

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	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,267,500		7,267,500	0	7,267,500	30.00
31.00	INTENSIVE CARE UNIT	1,194,656		1,194,656	0	1,194,656	31.00
43.00	NURSERY	496,312		496,312	0	496,312	43.00
44.00	SKILLED NURSING FACILITY	3,178,892		3,178,892	0	3,178,892	44.00
45.00	NURSING FACILITY	1,563,734		1,563,734	0	1,563,734	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,554,713		4,554,713	0	4,554,713	50.00
52.00	DELIVERY ROOM & LABOR ROOM	218,770		218,770	0	218,770	52.00
53.00	ANESTHESIOLOGY	173,002		173,002	0	173,002	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,256,918		3,256,918	0	3,256,918	54.00
57.00	CT SCAN	391,625		391,625	0	391,625	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	769,671		769,671	0	769,671	58.00
60.00	LABORATORY	5,356,599		5,356,599	0	5,356,599	60.00
65.00	RESPIRATORY THERAPY	567,952	0	567,952	0	567,952	65.00
66.00	PHYSICAL THERAPY	1,436,122	0	1,436,122	0	1,436,122	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,338,515		1,338,515	0	1,338,515	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	2,139,924		2,139,924	0	2,139,924	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,688,123		2,688,123	0	2,688,123	73.00
76.97	CARDIAC REHABILITATION	523,133		523,133	0	523,133	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	13,919,553		13,919,553	0	13,919,553	88.00
90.00	CLINIC	0		0	0	0	90.00
91.00	EMERGENCY	2,859,988		2,859,988	19,865	2,879,853	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,156,082		1,156,082		1,156,082	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	1,552,958		1,552,958	0	1,552,958	96.00
101.00	HOME HEALTH AGENCY	912,042		912,042		912,042	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	605,333		605,333		605,333	116.00
200.00	Subtotal (see instructions)	58,122,117	0	58,122,117	19,865	58,141,982	200.00
201.00	Less Observation Beds	1,156,082		1,156,082		1,156,082	201.00
202.00	Total (see instructions)	56,966,035	0	56,966,035	19,865	56,985,900	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/25/2012 5:44 pm

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	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,061,217		7,061,217			30.00
31.00	INTENSIVE CARE UNIT	1,240,481		1,240,481			31.00
43.00	NURSERY	373,345		373,345			43.00
44.00	SKILLED NURSING FACILITY	2,572,337		2,572,337			44.00
45.00	NURSING FACILITY	1,085,178		1,085,178			45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,624,753	11,421,819	17,046,572	0.267192	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	358,190	147,202	505,392	0.432872	0.000000	52.00
53.00	ANESTHESIOLOGY	601,263	1,225,775	1,827,038	0.094690	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,697,391	12,964,541	14,661,932	0.222134	0.000000	54.00
57.00	CT SCAN	1,991,651	12,050,815	14,042,466	0.027889	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	276,556	5,045,164	5,321,720	0.144628	0.000000	58.00
60.00	LABORATORY	5,310,603	21,991,124	27,301,727	0.196200	0.000000	60.00
65.00	RESPIRATORY THERAPY	1,939,042	451,537	2,390,579	0.237579	0.000000	65.00
66.00	PHYSICAL THERAPY	1,788,862	1,841,442	3,630,304	0.395593	0.000000	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,717,558	2,218,828	3,936,386	0.340037	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	2,569,323	794,937	3,364,260	0.636076	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,802,367	2,970,701	8,773,068	0.306406	0.000000	73.00
76.97	CARDIAC REHABILITATION	873	327,151	328,024	1.594801	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	19,162,015	19,162,015			88.00
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	2,189,670	10,708,041	12,897,711	0.221744	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	178,676	1,056,185	1,234,861	0.936204	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	2,746,816	2,746,816	0.565367	0.000000	96.00
101.00	HOME HEALTH AGENCY	0	1,026,960	1,026,960			101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	1,652,186	1,652,186			116.00
200.00	Subtotal (see instructions)	44,379,336	109,803,239	154,182,575			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	44,379,336	109,803,239	154,182,575			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	PPS Inpatient Ratio	
		11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	ADULTS & PEDIATRICS		30.00
31.00	INTENSIVE CARE UNIT		31.00
43.00	NURSERY		43.00
44.00	SKILLED NURSING FACILITY		44.00
45.00	NURSING FACILITY		45.00
	ANCILLARY SERVICE COST CENTERS		
50.00	OPERATING ROOM	0.267192	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.432872	52.00
53.00	ANESTHESIOLOGY	0.094690	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.222134	54.00
57.00	CT SCAN	0.027889	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.144628	58.00
60.00	LABORATORY	0.196200	60.00
65.00	RESPIRATORY THERAPY	0.237579	65.00
66.00	PHYSICAL THERAPY	0.395593	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340037	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.636076	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.306406	73.00
76.97	CARDIAC REHABILITATION	1.594801	76.97
	OUTPATIENT SERVICE COST CENTERS		
88.00	RURAL HEALTH CLINIC (RHC)		88.00
90.00	CLINIC	0.000000	90.00
91.00	EMERGENCY	0.223284	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.936204	92.00
	OTHER REIMBURSABLE COST CENTERS		
96.00	DURABLE MEDICAL EQUIP-RENTED	0.565367	96.00
101.00	HOME HEALTH AGENCY		101.00
	SPECIAL PURPOSE COST CENTERS		
113.00	INTEREST EXPENSE		113.00
116.00	HOSPICE		116.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part I Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	651,606	0	651,606	8,826	73.83	30.00
31.00	INTENSIVE CARE UNIT	88,750		88,750	745	119.13	31.00
43.00	NURSERY	30,855		30,855	589	52.39	43.00
44.00	SKILLED NURSING FACILITY	326,834		326,834	7,575	43.15	44.00
45.00	NURSING FACILITY	185,555		185,555	6,414	28.93	45.00
200.00	Total (lines 30-199)	1,283,600		1,283,600	24,149		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part I Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	3,993	294,803		30.00
31.00	INTENSIVE CARE UNIT	410	48,843		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	4,694	202,546		44.00
45.00	NURSING FACILITY	0	0		45.00
200.00	Total (lines 30-199)	9,097	546,192		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part II Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	664,559	17,046,572	0.038985	2,235,019	87,132	50.00
52.00	DELIVERY ROOM & LABOR ROOM	46,376	505,392	0.091762	0	0	52.00
53.00	ANESTHESIOLOGY	52,719	1,827,038	0.028855	239,161	6,901	53.00
54.00	RADIOLOGY-DIAGNOSTIC	956,386	14,661,932	0.065229	1,086,728	70,886	54.00
57.00	CT SCAN	84,676	14,042,466	0.006030	1,222,299	7,370	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	122,744	5,321,720	0.023065	196,890	4,541	58.00
60.00	LABORATORY	386,425	27,301,727	0.014154	3,181,284	45,028	60.00
65.00	RESPIRATORY THERAPY	27,954	2,390,579	0.011693	944,570	11,045	65.00
66.00	PHYSICAL THERAPY	85,789	3,630,304	0.023631	289,935	6,851	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,340	3,936,386	0.005421	623,165	3,378	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	34,106	3,364,260	0.010138	1,229,348	12,463	72.00
73.00	DRUGS CHARGED TO PATIENTS	110,086	8,773,068	0.012548	2,668,128	33,480	73.00
76.97	CARDIAC REHABILITATION	52,440	328,024	0.159866	634	101	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	663,078	19,162,015	0.034604	0	0	88.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	338,559	12,897,711	0.026250	1,375,536	36,108	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	103,654	1,234,861	0.083940	140,763	11,816	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	90,631	2,746,816	0.032995	0	0	96.00
200.00	Total (lines 50-199)	3,841,522	139,170,871		15,433,460	337,100	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	835,385	0	0	0	835,385	30.00
31.00	INTENSIVE CARE UNIT	67,971	0	0		67,971	31.00
43.00	NURSERY	0	0	0		0	43.00
44.00	SKILLED NURSING FACILITY	296,551	0	0		296,551	44.00
45.00	NURSING FACILITY	0	0	0		0	45.00
200.00	Total (lines 30-199)	1,199,907	0	0		1,199,907	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part III Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	8,826	94.65	3,993	377,937	0	30.00
31.00	INTENSIVE CARE UNIT	745	91.24	410	37,408	0	31.00
43.00	NURSERY	589	0.00	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	7,575	39.15	4,694	183,770	0	44.00
45.00	NURSING FACILITY	6,414	0.00	0	0	0	45.00
200.00	Total (lines 30-199)	24,149		9,097	599,115	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part III Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
		12.00	13.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	0		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
45.00	NURSING FACILITY	0	0		45.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	179,383	0	0	179,383	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	16,079	0	0	16,079	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	0	28,504	0	0	28,504	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	11,054	0	0	11,054	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	29,600	0	0	29,600	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	56,277	0	0	56,277	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	76,833	0	0	76,833	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	132,889	0	0	132,889	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50-199)	0	530,619	0	0	530,619	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	179,383	17,046,572	0.010523	0.010523	2,235,019	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	505,392	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	1,827,038	0.000000	0.000000	239,161	53.00
54.00	RADIOLOGY-DIAGNOSTIC	16,079	14,661,932	0.001097	0.001097	1,086,728	54.00
57.00	CT SCAN	0	14,042,466	0.000000	0.000000	1,222,299	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	5,321,720	0.000000	0.000000	196,890	58.00
60.00	LABORATORY	28,504	27,301,727	0.001044	0.001044	3,181,284	60.00
65.00	RESPIRATORY THERAPY	0	2,390,579	0.000000	0.000000	944,570	65.00
66.00	PHYSICAL THERAPY	11,054	3,630,304	0.003045	0.003045	289,935	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,936,386	0.000000	0.000000	623,165	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	3,364,260	0.000000	0.000000	1,229,348	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	8,773,068	0.000000	0.000000	2,668,128	73.00
76.97	CARDIAC REHABILITATION	29,600	328,024	0.090237	0.090237	634	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	56,277	19,162,015	0.002937	0.002937	0	88.00
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	76,833	12,897,711	0.005957	0.005957	1,375,536	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	132,889	1,234,861	0.107615	0.107615	140,763	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	2,746,816	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	530,619	139,170,871			15,433,460	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	23,519	2,940,796	30,946	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	278,666	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,192	3,769,005	4,135	0	0	54.00
57.00	CT SCAN	0	3,885,850	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	1,242,529	0	0	0	58.00
60.00	LABORATORY	3,321	1,491,289	1,557	0	0	60.00
65.00	RESPIRATORY THERAPY	0	199,838	0	0	0	65.00
66.00	PHYSICAL THERAPY	883	28,006	85	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	438,029	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	184,462	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	844,358	0	0	0	73.00
76.97	CARDIAC REHABILITATION	57	139,700	12,606	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	8,194	2,382,363	14,192	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	15,148	423,281	45,551	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50-199)	52,314	18,248,172	109,072	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	LABORATORY	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC (RHC)	0	0	88.00
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.267192	2,940,796	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.432872	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.094690	278,666	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.222134	3,769,005	0	0		54.00
57.00	CT SCAN	0.027889	3,885,850	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.144628	1,242,529	0	0		58.00
60.00	LABORATORY	0.196200	1,491,289	0	0		60.00
65.00	RESPIRATORY THERAPY	0.237579	199,838	0	0		65.00
66.00	PHYSICAL THERAPY	0.395593	28,006	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340037	438,029	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.636076	184,462	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.306406	844,358	0	7,968		73.00
76.97	CARDIAC REHABILITATION	1.594801	139,700	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0.000000					88.00
90.00	CLINIC	0.000000	0	0	0		90.00
91.00	EMERGENCY	0.221744	2,382,363	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.936204	423,281	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0.565367	0	0	0		96.00
200.00	Subtotal (see instructions)		18,248,172	0	7,968		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		18,248,172	0	7,968		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	785,757	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	26,387	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	837,224	0	0		54.00
57.00	CT SCAN	108,372	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	179,704	0	0		58.00
60.00	LABORATORY	292,591	0	0		60.00
65.00	RESPIRATORY THERAPY	47,477	0	0		65.00
66.00	PHYSICAL THERAPY	11,079	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	148,946	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	117,332	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	258,716	0	2,441		73.00
76.97	CARDIAC REHABILITATION	222,794	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC (RHC)	0	0	0		88.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	528,275	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	396,277	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Subtotal (see instructions)	3,960,931	0	2,441		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	3,960,931	0	2,441		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	179,383	0	0	179,383	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	16,079	0	0	16,079	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	0	28,504	0	0	28,504	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	11,054	0	0	11,054	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	29,600	0	0	29,600	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	56,277	0	0	56,277	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	76,833	0	0	76,833	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	132,889	0	0	132,889	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50-199)	0	530,619	0	0	530,619	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	179,383	17,046,572	0.010523	0.010523	8,257	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	505,392	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	1,827,038	0.000000	0.000000	1,691	53.00
54.00	RADIOLOGY-DIAGNOSTIC	16,079	14,661,932	0.001097	0.001097	25,841	54.00
57.00	CT SCAN	0	14,042,466	0.000000	0.000000	11,912	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	5,321,720	0.000000	0.000000	0	58.00
60.00	LABORATORY	28,504	27,301,727	0.001044	0.001044	45,305	60.00
65.00	RESPIRATORY THERAPY	0	2,390,579	0.000000	0.000000	442,378	65.00
66.00	PHYSICAL THERAPY	11,054	3,630,304	0.003045	0.003045	897,867	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,936,386	0.000000	0.000000	163,480	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	3,364,260	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	8,773,068	0.000000	0.000000	523,468	73.00
76.97	CARDIAC REHABILITATION	29,600	328,024	0.090237	0.090237	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	56,277	19,162,015	0.002937	0.002937	0	88.00
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	76,833	12,897,711	0.005957	0.005957	381	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	132,889	1,234,861	0.107615	0.107615	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	2,746,816	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	530,619	139,170,871			2,120,580	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	87	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	28	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	47	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	2,734	0	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	2	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50-199)	2,898	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC (RHC)	0	0		88.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.267192	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.432872	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.094690	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.222134	0	0	0		54.00
57.00	CT SCAN	0.027889	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.144628	0	0	0		58.00
60.00	LABORATORY	0.196200	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0.237579	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.395593	0	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340037	0	306	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.636076	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.306406	0	163	789		73.00
76.97	CARDIAC REHABILITATION	1.594801	0	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC (RHC)	0.000000					88.00
90.00	CLINIC	0.000000	0	0	0		90.00
91.00	EMERGENCY	0.221744	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.936204	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	DURABLE MEDICAL EQUIP-RENTED	0.565367	0	0	0		96.00
200.00	Subtotal (see instructions)		0	469	789		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	469	789		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Costs PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	104	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	50	242		73.00
76.97	CARDIAC REHABILITATION	0	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC (RHC)	0	0	0		88.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Subtotal (see instructions)	0	154	242		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	154	242		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,826	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,826	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,826	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,993	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,267,500	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,267,500	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	8,259,521	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	8,259,521	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.879894	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)	935.82	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)	7,267,500	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)	823.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,287,916	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)	3,287,916	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,194,656	745	1,603.57	410	657,464	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)	4,138,380	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,083,760	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)	758,991	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	389,414	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,148,405	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,935,355	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,404	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	823.42	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,156,082	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	651,606	7,267,500	0.089660	1,156,082	103,654	90.00
91.00	Nursing School cost	835,385	7,267,500	0.114948	1,156,082	132,889	91.00
92.00	Allied health cost	0	7,267,500	0.000000	1,156,082	0	92.00
93.00	All other Medical Education	0	7,267,500	0.000000	1,156,082	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,575	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,575	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,575	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,694	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,178,892	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,178,892	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,573,037	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,573,037	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.235463	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)	339.67	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,178,892	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	3,178,892	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	419.66	71.00
72.00	Program routine service cost (line 9 x line 71)	1,969,884	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,969,884	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,969,884	83.00
84.00	Program inpatient ancillary services (see instructions)	693,684	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,663,568	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	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: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		3,422,625		30.00
31.00	INTENSIVE CARE UNIT		731,845		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.267192	2,235,019	597,179	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.432872	0	0	52.00
53.00	ANESTHESIOLOGY	0.094690	239,161	22,646	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.222134	1,086,728	241,399	54.00
57.00	CT SCAN	0.027889	1,222,299	34,089	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.144628	196,890	28,476	58.00
60.00	LABORATORY	0.196200	3,181,284	624,168	60.00
65.00	RESPIRATORY THERAPY	0.237579	944,570	224,410	65.00
66.00	PHYSICAL THERAPY	0.395593	289,935	114,696	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340037	623,165	211,899	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.636076	1,229,348	781,959	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.306406	2,668,128	817,530	73.00
76.97	CARDIAC REHABILITATION	1.594801	634	1,011	76.97
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.223284	1,375,536	307,135	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.936204	140,763	131,783	92.00
	OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	0.565367	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		15,433,460	4,138,380	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)		15,433,460		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.267192	8,257	2,206	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.432872	0	0	52.00
53.00	ANESTHESIOLOGY	0.094690	1,691	160	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.222134	25,841	5,740	54.00
57.00	CT SCAN	0.027889	11,912	332	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.144628	0	0	58.00
60.00	LABORATORY	0.196200	45,305	8,889	60.00
65.00	RESPIRATORY THERAPY	0.237579	442,378	105,100	65.00
66.00	PHYSICAL THERAPY	0.395593	897,867	355,190	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.340037	163,480	55,589	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.636076	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.306406	523,468	160,394	73.00
76.97	CARDIAC REHABILITATION	1.594801	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.221744	381	84	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.936204	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	0.565367	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		2,120,580	693,684	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)		2,120,580		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part A Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Hospital	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS			
1.00	DRG Amounts Other than Outlier Payments	5,645,228		1.00
2.00	Outlier payments for discharges. (see instructions)	33,447		2.00
3.00	Managed Care Simulated Payments	0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	42.85		4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00		11.00
12.00	Current year allowable FTE (see instructions)	0.00		12.00
13.00	Total allowable FTE count for the prior year.	0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00		15.00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000		21.00
22.00	IME payment adjustment (see instructions)	0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment. (see instructions)	0.000000		27.00
28.00	IME Adjustment (see instructions)	0		28.00
29.00	Total IME payment (sum of lines 22 and 28)	0		29.00
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.07		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	21.28		31.00
32.00	Sum of lines 30 and 31	25.35		32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.13		33.00
34.00	Disproportionate share adjustment (see instructions)	571,862		34.00
	Additional payment for high percentage of ESRD beneficiary discharges			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0		46.00
47.00	Subtotal (see instructions)	6,250,537		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	7,078,189		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	7,078,189		49.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part A Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Hospital	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	459,615		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs	415,345		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	52,314		58.00
59.00	Total (sum of amounts on lines 49 through 58)	8,005,463		59.00
60.00	Primary payer payments	5,190		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	8,000,273		61.00
62.00	Deductibles billed to program beneficiaries	805,528		62.00
63.00	Coinsurance billed to program beneficiaries	12,703		63.00
64.00	Allowable bad debts (see instructions)	113,046		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	79,132		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	95,717		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,261,174		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Outlier payments reconciliation	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	651,832		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	7,913,006		71.00
72.00	Interim payments	7,413,075		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	499,931		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	7,860		75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,441	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,851,859	2.00
3.00	PPS payments	3,480,618	3.00
4.00	Outlier payment (see instructions)	721	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.862	5.00
6.00	Line 2 times line 5	3,320,302	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	109,072	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,441	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	7,968	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)	7,968	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	7,968	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,527	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)	2,441	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)	3,590,411	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	877,907	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)	2,714,945	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)	2,714,945	30.00
31.00	Primary payer payments	187	31.00
32.00	Subtotal (line 30 minus line 31)	2,714,758	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)	157,774	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	110,442	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	131,356	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,825,200	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,825,200	40.00
41.00	Interim payments	3,087,230	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)	-262,030	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	1,874	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	396	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	396	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,258	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)	1,258	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,258	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	862	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)	396	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)	96	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	300	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)	300	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	300	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	300	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	300	40.00
41.00	Interim payments	294	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)	6	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,327,499		3,028,161	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	06/10/2011	868,409	02/11/2011	59,069	3.01
3.02		02/11/2011	217,167		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)		1,085,576		59,069	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)		7,413,075		3,087,230	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		499,931		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		262,030	6.02
7.00	Total Medicare program liability (see instructions)		7,913,006		2,825,200	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: 140001	Period:	Worksheet E-1
Component CCN: 145572	From 07/01/2010 To 06/30/2011	Part I Date/Time Prepared: 1/25/2012 5:44 pm
Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,299,117		294	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	02/11/2011	33,379		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)		33,379		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)		1,332,496		294	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		153,289		6	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,485,785		300	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VI Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,564,479	1.00
2.00	Routine service other pass through costs	183,770	2.00
3.00	Ancillary service other pass through costs	2,898	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,751,147	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	265,362	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,485,785	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,485,785	15.00
16.00	Interim payments	1,332,496	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	153,289	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	3,154	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G | Date/Time Prepared: 1/25/2012 5:44 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	2,320,251	0	0	0	3.00
4.00	Accounts receivable	12,486,254	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,515,291	0	0	0	7.00
8.00	Prepaid expenses	1,707,196	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,028,992	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,748,457	0	0	0	12.00
13.00	Land improvements	1,085,463	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	58,439,479	0	0	0	15.00
16.00	Accumulated depreciation	-49,029,365	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	23,956,632	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	14,640,934	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)	52,841,600	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	58,101,878	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	58,101,878	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	128,972,470	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,823,287	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,171,904	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	700,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	828,535	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,523,726	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	29,085,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,515,407	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	35,600,407	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	43,124,133	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	85,848,337				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)	85,848,337	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	128,972,470	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/25/2012 5:44 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		72,529,537		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,318,800				2.00
3.00	Total (sum of line 1 and line 2)		85,848,337		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)		85,848,337		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)		85,848,337		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/25/2012 5:44 pm

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)		0		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		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)		0		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00		0		0			13.00
14.00		0		0			14.00
15.00		0		0			15.00
16.00		0		0			16.00
17.00		0		0			17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 1/25/2012 5:44 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,259,521		8,259,521	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,573,037		2,573,037	7.00
8.00	NURSING FACILITY	1,085,178		1,085,178	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,917,736		11,917,736	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,400,062		1,400,062	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)	1,400,062		1,400,062	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,317,798		13,317,798	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	3,064,517	15,666,810	18,731,327	19.00
20.00	RURAL HEALTH CLINIC (RHC)	0	19,162,015	19,162,015	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,026,960	1,026,960	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,653,536	1,653,536	26.00
27.00	DME	0	2,746,816	2,746,816	27.00
27.01	OPERATING ROOM	8,324,522	12,606,763	20,931,285	27.01
27.02	DELIVERY ROOM & LABOR ROOM	369,295	149,227	518,522	27.02
27.03	ANESTHESIOLOGY	1,761,225	3,146,284	4,907,509	27.03
27.04	RADIOLOGY-DIAGNOSTIC	1,743,302	13,201,887	14,945,189	27.04
27.05	CT SCAN	2,017,379	12,342,298	14,359,677	27.05
27.06	MRI	276,556	5,229,000	5,505,556	27.06
27.07	LABORATORY	5,452,780	20,635,606	26,088,386	27.07
27.08	RESPIRATORY THERAPY	1,941,824	463,278	2,405,102	27.08
27.09	PHYSICAL THERAPY	1,792,573	1,901,492	3,694,065	27.09
27.10	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,743,435	2,039,149	3,782,584	27.10
27.11	IMPL. DEV. CHARGED TO PATIENT	0	0	0	27.11
27.12	DRUGS CHARGED TO PATIENTS	5,866,016	2,989,054	8,855,070	27.12
27.13	CARDIAC REHAB	873	332,315	333,188	27.13
27.14	NURSING ADMIN	112	5,638	5,750	27.14
27.15	DIETARY	0	22,115	22,115	27.15
27.16	PHYSICIAN	0	469,564	469,564	27.16
27.17	NURSERY	380,520	385	380,905	27.17
27.18		0	0	0	27.18
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	48,052,727	115,790,192	163,842,919	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		67,141,776		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	PROVISION FOR UNCOLLECTIBLE ACCOUNTS	5,406,369			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)		5,406,369		36.00
37.00	EXPENSES IN OTHER OPERATION REV	25,873			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)		25,873		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		72,522,272		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/25/2012 5:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	163,842,919	1.00
2.00	Less contractual allowances and discounts on patients' accounts	89,656,932	2.00
3.00	Net patient revenues (line 1 minus line 2)	74,185,987	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	72,522,272	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,663,715	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	62,100	6.00
7.00	Income from investments	2,978,058	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	CY CHANGE IN UNREALIZED GAINS	4,281,605	24.00
24.01	CHANGE IN FV OF INT. RATE SWAP AGREE	816,539	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	94,665	24.02
24.03	INCREASE IN TEMP. RESTRICTED ASSETS	13,015	24.03
24.04	CHANGE IN BENE. INT. PERPETUAL TRUST	1,093,515	24.04
24.05	GHA ACCRUED NET PATIENT REVENUE AT Y	48,083	24.05
24.06	OTHER OPERATING REVENUE	2,290,311	24.06
24.07		0	24.07
24.08		0	24.08
24.09		0	24.09
24.10		0	24.10
25.00	Total other income (sum of lines 6-24)	11,677,891	25.00
26.00	Total (line 5 plus line 25)	13,341,606	26.00
27.00	ROUNDING	22,806	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	22,806	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,318,800	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H

HHA CCN: 147142 | Date/Time Prepared: 1/25/2012 5:44 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	110,229	0	0	0	48,936	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	267,632	0	10,727	0	0	6.00
7.00	Physical Therapy	55,923	0	0	0	0	7.00
8.00	Occupational Therapy	8,124	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	769	9.00
10.00	Medical Social Services	19,779	0	0	0	0	10.00
11.00	Home Health Aide	27,143	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	13,592	12.00
13.00	Drugs	0	0	0	0	1,166	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	488,830	0	10,727	0	64,463	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H

HHA CCN: 147142 | Date/Time Prepared: 1/25/2012 5:44 pm

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		Total (sum of cols. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	159,165	6,835	166,000	-1,573	164,427	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	278,359	0	278,359	0	278,359	6.00
7.00	Physical Therapy	55,923	0	55,923	0	55,923	7.00
8.00	Occupational Therapy	8,124	0	8,124	0	8,124	8.00
9.00	Speech Pathology	769	0	769	0	769	9.00
10.00	Medical Social Services	19,779	0	19,779	0	19,779	10.00
11.00	Home Health Aide	27,143	0	27,143	0	27,143	11.00
12.00	Supplies (see instructions)	13,592	0	13,592	0	13,592	12.00
13.00	Drugs	1,166	0	1,166	0	1,166	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	564,020	6,835	570,855	-1,573	569,282	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
			Bldgs & Fixtures	Movable Equipment			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0				1.00
2.00	Capital Related - Movable Equipment	0		0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	164,427	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	278,359	0	0	0	0	6.00
7.00	Physical Therapy	55,923	0	0	0	0	7.00
8.00	Occupational Therapy	8,124	0	0	0	0	8.00
9.00	Speech Pathology	769	0	0	0	0	9.00
10.00	Medical Social Services	19,779	0	0	0	0	10.00
11.00	Home Health Aide	27,143	0	0	0	0	11.00
12.00	Supplies (see instructions)	13,592	0	0	0	0	12.00
13.00	Drugs	1,166	0	0	0		13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	569,282	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

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		Subtotal (cols. 0-4)	Administrative & General	Total (cols. 4A + 5)		
		4A.00	5.00	6.00		
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0				1.00
2.00	Capital Related - Movable Equipment	0				2.00
3.00	Plant Operation & Maintenance	0				3.00
4.00	Transportation					4.00
5.00	Administrative and General	164,427	164,427			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	278,359	113,053	391,412		6.00
7.00	Physical Therapy	55,923	22,712	78,635		7.00
8.00	Occupational Therapy	8,124	3,299	11,423		8.00
9.00	Speech Pathology	769	312	1,081		9.00
10.00	Medical Social Services	19,779	8,033	27,812		10.00
11.00	Home Health Aide	27,143	11,024	38,167		11.00
12.00	Supplies (see instructions)	13,592	5,520	19,112		12.00
13.00	Drugs	1,166	474	1,640		13.00
14.00	DME	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0		17.00
18.00	Clinic	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0		19.00
20.00	Day Care Program	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0		21.00
22.00	Homemaker Service	0	0	0		22.00
23.00	All Others (specify)	0	0	0		23.00
24.00	Total (sum of lines 1-23)	404,855		569,282		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part II | Date/Time Prepared: 1/25/2012 5:44 pm

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		Capital Related Costs					
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		1.00	2.00	3.00	4.00	5A.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-164,427	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-164,427	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-1 Part II Date/Time Prepared: 1/25/2012 5:44 pm

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		Administrative & General (ACCUM. COST)		
		5.00		
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation (see instructions)			4.00
5.00	Administrative and General	404,855		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	278,359		6.00
7.00	Physical Therapy	55,923		7.00
8.00	Occupational Therapy	8,124		8.00
9.00	Speech Pathology	769		9.00
10.00	Medical Social Services	19,779		10.00
11.00	Home Health Aide	27,143		11.00
12.00	Supplies (see instructions)	13,592		12.00
13.00	Drugs	1,166		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0		15.00
16.00	Respiratory Therapy	0		16.00
17.00	Private Duty Nursing	0		17.00
18.00	Clinic	0		18.00
19.00	Health Promotion Activities	0		19.00
20.00	Day Care Program	0		20.00
21.00	Home Delivered Meals Program	0		21.00
22.00	Homemaker Service	0		22.00
23.00	All Others (specify)	0		23.00
24.00	Total (sum of lines 1-23)	404,855		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	164,427		25.00
26.00	Unit Cost Multiplier	0.406138		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 | Period: From 07/01/2010 | Worksheet H-2 Part I
HHA CCN: 147142 | To 06/30/2011 | Date/Time Prepared: 1/25/2012 5:44 pm

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			CAPITAL RELATED COSTS				
		HHA Trial Balance (1)	NEW BLDG & FIXT	NEW CARDIAC REHAB	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General	0	0	0	30,628	96,249	1.00
2.00	Skilled Nursing Care	391,412	0	0	0	0	2.00
3.00	Physical Therapy	78,635	0	0	0	0	3.00
4.00	Occupational Therapy	11,423	0	0	0	0	4.00
5.00	Speech Pathology	1,081	0	0	0	0	5.00
6.00	Medical Social Services	27,812	0	0	0	0	6.00
7.00	Home Health Aide	38,167	0	0	0	0	7.00
8.00	Supplies (see instructions)	19,112	0	0	0	0	8.00
9.00	Drugs	1,640	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	569,282	0	0	30,628	96,249	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

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		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
1.00	Administrative and General	126,877	27,676	0	0	0	1.00
2.00	Skilled Nursing Care	391,412	85,380	0	0	0	2.00
3.00	Physical Therapy	78,635	17,153	0	0	0	3.00
4.00	Occupational Therapy	11,423	2,492	0	0	0	4.00
5.00	Speech Pathology	1,081	236	0	0	0	5.00
6.00	Medical Social Services	27,812	6,067	0	0	0	6.00
7.00	Home Health Aide	38,167	8,326	0	0	0	7.00
8.00	Supplies (see instructions)	19,112	4,169	0	0	0	8.00
9.00	Drugs	1,640	358	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	696,159	151,857	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I Date/Time Prepared: 1/25/2012 5:44 pm

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		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	313	493	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	313	493	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

HHA CCN: 147142 | Home Health Agency I | PPS

		MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	20.00	24.00	25.00	26.00	
1.00	Administrative and General	0	63,220	217,773	0	217,773	1.00
2.00	Skilled Nursing Care	0	0	476,792	0	476,792	2.00
3.00	Physical Therapy	0	0	95,788	0	95,788	3.00
4.00	Occupational Therapy	0	0	13,915	0	13,915	4.00
5.00	Speech Pathology	0	0	1,317	0	1,317	5.00
6.00	Medical Social Services	0	0	33,879	0	33,879	6.00
7.00	Home Health Aide	0	0	46,493	0	46,493	7.00
8.00	Supplies (see instructions)	0	0	23,281	0	23,281	8.00
9.00	Drugs	0	0	2,804	0	2,804	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	63,220	912,042	0	912,042	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-2 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

HHA CCN: 147142 | Home Health Agency I | PPS

		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	149,555	626,347		2.00
3.00	Physical Therapy	30,046	125,834		3.00
4.00	Occupational Therapy	4,365	18,280		4.00
5.00	Speech Pathology	413	1,730		5.00
6.00	Medical Social Services	10,627	44,506		6.00
7.00	Home Health Aide	14,584	61,077		7.00
8.00	Supplies (see instructions)	7,303	30,584		8.00
9.00	Drugs	880	3,684		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	217,773	912,042		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.313672			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-2 Part II Date/Time Prepared: 1/25/2012 5:44 pm

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		CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
		1.00	1.01	2.00	4.00	5A	
1.00	Administrative and General	0	0	30,494	488,830	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	30,494	488,830		20.00
21.00	Total cost to be allocated	0	0	30,628	96,249		21.00
22.00	Unit cost multiplier	0.000000	0.000000	1.004394	0.196897		22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

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

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		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	126,877	0	0	0	0	1.00
2.00	Skilled Nursing Care	391,412	0	0	0	0	2.00
3.00	Physical Therapy	78,635	0	0	0	0	3.00
4.00	Occupational Therapy	11,423	0	0	0	0	4.00
5.00	Speech Pathology	1,081	0	0	0	0	5.00
6.00	Medical Social Services	27,812	0	0	0	0	6.00
7.00	Home Health Aide	38,167	0	0	0	0	7.00
8.00	Supplies (see instructions)	19,112	0	0	0	0	8.00
9.00	Drugs	1,640	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	696,159	0	0	0	0	20.00
21.00	Total cost to be allocated	151,857	0	0	0	0	21.00
22.00	Unit cost multiplier	0.218136	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-2 Part II Date/Time Prepared: 1/25/2012 5:44 pm

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		CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	13,431	1,166	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	13,431	1,166	0	20.00
21.00	Total cost to be allocated	0	0	313	493	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.023304	0.422813	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140001 HHA CCN: 147142	Period: From 07/01/2010 To 06/30/2011	Worksheet H-2 Part II Date/Time Prepared: 1/25/2012 5:44 pm
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		NURSING SCHOOL (ASSIGNED TIME)		
		20.00		
1.00	Administrative and General	34,600		1.00
2.00	Skilled Nursing Care	0		2.00
3.00	Physical Therapy	0		3.00
4.00	Occupational Therapy	0		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	0		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
20.00	Total (sum of lines 1-19)	34,600		20.00
21.00	Total cost to be allocated	63,220		21.00
22.00	Unit cost multiplier	1.827168		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-3 Parts I-II | Date/Time Prepared: 1/25/2012 5:44 pm

HHA CCN: 147142 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	626,347		626,347	4,479	1.00
2.00	Physical Therapy	3.00	125,834	0	125,834	577	2.00
3.00	Occupational Therapy	4.00	18,280	0	18,280	139	3.00
4.00	Speech Pathology	5.00	1,730	0	1,730	10	4.00
5.00	Medical Social Services	6.00	44,506		44,506	65	5.00
6.00	Home Health Aide	7.00	61,077		61,077	450	6.00
7.00	Total (sum of lines 1-6)		877,774	0	877,774	5,720	7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B: Not Subject to Deductibles & Coinsurance	Program Visits Part B: Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care		99914	0	0		8.00
9.00	Physical Therapy		99914	0	0		9.00
10.00	Occupational Therapy		99914	0	0		10.00
11.00	Speech Pathology		99914	0	0		11.00
12.00	Medical Social Services		99914	0	0		12.00
13.00	Home Health Aide		99914	0	0		13.00
14.00	Total (sum of lines 8-13)			0	0		14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	8.00	30,584	0	30,584	23,406	15.00
16.00	Cost of Drugs	9.00	3,684	0	3,684	0	16.00

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
		0	1.00	2.00	3.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00	Physical Therapy	66.00	0.395593	0	0	1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.340037	0	0	4.00
5.00	Cost of Drugs	73.00	0.306406	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001	Period: From 07/01/2010	Worksheet H-3 Parts I-II
HHA CCN: 147142	To 06/30/2011	Date/Time Prepared: 1/25/2012 5:44 pm
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	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	139.84	854	1,298			1.00
2.00	Physical Therapy	218.08	235	146			2.00
3.00	Occupational Therapy	131.51	48	37			3.00
4.00	Speech Pathology	173.00	6	0			4.00
5.00	Medical Social Services	684.71	8	20			5.00
6.00	Home Health Aide	135.73	187	180			6.00
7.00	Total (sum of lines 1-6)		1,338	1,681			7.00

	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	9.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	1.306674	3,896	19,510	0		15.00
16.00	Cost of Drugs	0.000000	0	0	0		16.00

	Cost Center Description	Transfer to Part I as Indicated		
		4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS			
1.00	Physical Therapy	col. 2, line 2.00		1.00
2.00	Occupational Therapy			2.00
3.00	Speech Pathology			3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00		4.00
5.00	Cost of Drugs	col. 2, line 16.00		5.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2010 To 06/30/2011 | Worksheet H-3 Parts I-II Date/Time Prepared: 1/25/2012 5:44 pm

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	Cost Center Description	Cost of Services: Part A	Part B: Not Subject to Deductibles & Coinsurance	Part B: Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)		
		9.00	10.00	11.00	12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
	Cost Per Visit Computation						
1.00	Skilled Nursing Care	119,423	181,512		300,935		1.00
2.00	Physical Therapy	51,249	31,840		83,089		2.00
3.00	Occupational Therapy	6,312	4,866		11,178		3.00
4.00	Speech Pathology	1,038	0		1,038		4.00
5.00	Medical Social Services	5,478	13,694		19,172		5.00
6.00	Home Health Aide	25,382	24,431		49,813		6.00
7.00	Total (sum of lines 1-6)	208,882	256,343		465,225		7.00

	Cost Center Description					
		10.00	11.00	12.00		
	Limitation Cost Computation					
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00

	Cost Center Description	Cost of Services: Part A	Part B: Not Subject to Deductibles & Coinsurance	Part B: Subject to Deductibles & Coinsurance		
		9.00	10.00	11.00		
	Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	5,091	25,493	0		15.00
16.00	Cost of Drugs	0	0	0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 HHA CCN: 147142	Period: From 07/01/2010 To 06/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	221,088	282,438	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	221,088	282,438	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	221,088	282,438	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	143,342	159,591	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	7,946	16,430	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	6,840	11,832	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,538	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	3,159	9,032	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	161,287	200,423	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	161,287	200,423	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	161,287	200,423	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	161,287	200,423	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	161,287	200,423	31.00
32.00	Interim payments (see instructions)	161,287	200,423	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140001 HHA CCN: 147142	Period: From 07/01/2010 To 06/30/2011	Worksheet H-5 Date/Time Prepared: 1/25/2012 5:44 pm
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		161,287		200,423	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		161,287		200,423	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		161,287		200,423	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K

Hospice CCN: 141558 | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	272,685	0	0	12,742	79,406	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	272,685	0	0	12,742	79,406	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K

Hospice CCN: 141558 | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	364,833	6,835	371,668	0	371,668	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	364,833	6,835	371,668	0	371,668	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-1

Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	83,523	0	0	0	130,767	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	83,523	0	0	0	130,767	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-1

Hospice CCN: 141558 | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		12,879	45,516	272,685		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	12,879	45,516	272,685		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140001 | Hospice CCN: 141558 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-3 | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140001 | Hospice CCN: 141558 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-3 | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	12,742	12,742		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	12,742	12,742		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-4 Part I Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	371,668	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	371,668	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-4 Part I Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.		0				1.00
2.00	Capital Related Costs-Movable Equip.		0				2.00
3.00	Plant Operation and Maintenance		0				3.00
4.00	Transportation - Staff		0				4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	0				6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	371,668	0	371,668		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	371,668	0	371,668		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Hospice CCN: 141558 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-4 Part II | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-4 Part II Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	0	371,668		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	371,668		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		0		39.00
40.00	Unit Cost Multiplier		0.000000		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-5 Part I Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
			NEW BLDG & FIXT	NEW CARDIAC REHAB	NEW MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General		0	0	8,370	53,691	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	371,668	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	371,668	0	0	8,370	53,691	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-5 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice CCN: 141558 | Hospice I

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
1.00	Administrative and General	62,061	13,538	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	371,668	81,073	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	433,729	94,611	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)	0.000000					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part I
Date/Time Prepared:
1/25/2012 5:44 pm

Hospice I

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	7	42,270	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	7	42,270	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 | Hospice CCN: 141558 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-5 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	
		16.00	20.00	24.00	25.00	26.00	
1.00	Administrative and General	0	34,716	110,315			1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	452,741	0	452,741	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	42,277	0	42,277	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	34,716	605,333	0	605,333	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-5 Part I | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice CCN: 141558 | Hospice I

	Cost Center Description	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Inpatient - General Care	0	0		2.00
3.00	Inpatient - Respite Care	0	0		3.00
4.00	Physician Services	0	0		4.00
5.00	Nursing Care	100,894	553,635		5.00
6.00	Nursing Care-Continuous Home Care	0	0		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech/ Language Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Spiritual Counseling	0	0		11.00
12.00	Dietary Counseling	0	0		12.00
13.00	Counseling - Other	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		15.00
16.00	Other	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	9,421	51,698		17.00
18.00	Analgesics	0	0		18.00
19.00	Sedatives / Hypnotics	0	0		19.00
20.00	Other - Specify	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0		21.00
22.00	Patient Transportation	0	0		22.00
23.00	Imaging Services	0	0		23.00
24.00	Labs and Diagnostics	0	0		24.00
25.00	Medical Supplies	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		26.00
27.00	Radiation Therapy	0	0		27.00
28.00	Chemotherapy	0	0		28.00
29.00	Other	0	0		29.00
30.00	Bereavement Program Costs	0	0		30.00
31.00	Volunteer Program Costs	0	0		31.00
32.00	Fundraising	0	0		32.00
33.00	Other Program Costs	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)		605,333		34.00
35.00	Unit Cost Multiplier (see instructions)	0.222850			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
1/25/2012 5:44 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS				Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)		
		1.00	1.01	2.00	4.00	5A	
1.00	Administrative and General	0	0	8,333	272,685	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	8,333	272,685		34.00
35.00	Total cost to be allocated	0	0	8,370	53,691		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	1.004440	0.196898		36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
1/25/2012 5:44 pm

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	62,061	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	371,668	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	433,729	0	0	0	0	34.00
35.00	Total cost to be allocated	94,611	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.218134	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
1/25/2012 5:44 pm

Hospice I

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	285	99,995	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	285	99,995	0	34.00
35.00	Total cost to be allocated	0	0	7	42,270	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.024561	0.422721	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
1/25/2012 5:44 pm

Hospice I

	Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)		
		20.00		
1.00	Administrative and General	19,000		1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	0		4.00
5.00	Nursing Care	0		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	0		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	19,000		34.00
35.00	Total cost to be allocated	34,716		35.00
36.00	Unit Cost Multiplier (see instructions)	1.827158		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-5 Part III | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice CCN: 141558

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.395593	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.306406	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.565367	0	0	5.00
6.00	LABORATORY	60.00	0.196200	0	0	6.00
6.01	LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.340037	0	0	7.00
7.30	IMPL. DEV. CHARGED TO PATIENT	71.30				7.30
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
10.97	CARDIAC REHABILITATION	76.97	1.594801	0	0	10.97
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140001 | Period: From 07/01/2010 To 06/30/2011 | Worksheet K-6

Hospice CCN: 141558 | Date/Time Prepared: 1/25/2012 5:44 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				605,333	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				5,208	2.00
3.00	Average cost per diem (line 1 divided by line 2)				116.23	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	4,250				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	493,977				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		333			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		38,705			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			625		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			72,644		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140001	Period: From 07/01/2010 To 06/30/2011	Worksheet L Parts I-III Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	455,312	1.00
2.00	Capital DRG outlier payments	4,303	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	22.66	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	459,615	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 140001 | Component CCN: 143493 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-1 | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	520,155	0	520,155	0	520,155	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,579,770	0	1,579,770	-53,718	1,526,052	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	496,975	7,054	504,029	-9,026	495,003	9.00
10.00	Subtotal (sum of lines 1-9)	2,596,900	7,054	2,603,954	-62,744	2,541,210	10.00
11.00	Physician Services Under Agreement	0	7,310,110	7,310,110	-130,900	7,179,210	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	7,310,110	7,310,110	-130,900	7,179,210	14.00
15.00	Medical Supplies	0	141,809	141,809	-2,539	139,270	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	23,903	23,903	-428	23,475	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	165,712	165,712	-2,967	162,745	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,596,900	7,482,876	10,079,776	-196,611	9,883,165	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	17,760	17,760	-318	17,442	29.00
30.00	Administrative Costs	22,323	126,762	149,085	-2,496	146,589	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	22,323	144,522	166,845	-2,814	164,031	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,619,223	7,627,398	10,246,621	-199,425	10,047,196	32.00

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

Provider CCN: 140001 | Component CCN: 143493 | Period: From 07/01/2010 To 06/30/2011 | Worksheet M-1 | Date/Time Prepared: 1/25/2012 5:44 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	520,155		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,526,052		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	495,003		9.00
10.00	Subtotal (sum of lines 1-9)	0	2,541,210		10.00
11.00	Physician Services Under Agreement	0	7,179,210		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	7,179,210		14.00
15.00	Medical Supplies	0	139,270		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	23,475		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	162,745		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	9,883,165		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-5,507	11,935		29.00
30.00	Administrative Costs	-91,957	54,632		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-97,464	66,567		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-97,464	9,949,732		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140001 | Period: From 07/01/2010 | Worksheet M-2
Component CCN: 143493 | To 06/30/2011 | Date/Time Prepared: 1/25/2012 5:44 pm
Title XVIII | Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	16.50	76,018	4,200	69,300		1.00
2.00	Physician Assistant	2.50	6,104	2,100	5,250		2.00
3.00	Nurse Practitioner	2.30	8,422	2,100	4,830		3.00
4.00	Subtotal (sum of lines 1-3)	21.30	90,544		79,380	90,544	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)	21.30	90,544			90,544	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)					9,883,165	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					9,883,165	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					66,567	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					3,969,821	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,036,388	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					4,036,388	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					4,036,388	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					13,919,553	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2010 To 06/30/2011	Worksheet M-3 Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		13,919,553	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		45,791	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		13,873,762	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		90,544	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)		90,544	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		153.23	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	153.23	153.23	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	8,455	8,454	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	1,295,560	1,295,406	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) *	1,295,560	1,295,406	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total program non-preventive costs ((line 16 minus line 16.03) times 80%)		874,702	16.04
16.05	Total program cost (see instructions)	1,036,448	874,702	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		202,028	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)		1,911,150	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,789	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,919,939	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		1,919,939	26.00
27.00	Interim payments		1,834,384	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)		85,555	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		34,911	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2010 To 06/30/2011	Worksheet M-4 Date/Time Prepared: 1/25/2012 5:44 pm
	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)	2,541,210	2,541,210	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.004374	0.004561	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	11,115	11,590	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,154	6,652	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	14,269	18,242	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	9,883,165	9,883,165	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	4,036,388	4,036,388	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001444	0.001846	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,829	7,451	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	20,098	25,693	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1,572	1,639	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	12.78	15.68	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	138	448	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,764	7,025	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)		45,791	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)		8,789	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140001 Component CCN: 143493	Period: From 07/01/2010 To 06/30/2011	Worksheet M-5 Date/Time Prepared: 1/25/2012 5:44 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,746,309	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		02/11/2011	88,075	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)		88,075	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,834,384	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		85,555	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,919,939	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00